Notice of Request for Proposal

SOLICITATION NO.: AD040404

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Offeror: _____

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

Solicitation Contact Person:

Gecola Ward
State Procurement Office
FAX: 602-542-5508
Gecola.ward@ad.state.az..us

Offeror:

(**PLEASE PROVIDE NAME AND ADDRESS OF FIRM HERE**

Offeror Contact:

Solicitation Issue Date: March 18, 2004

DESCRIPTION:

INTEGRATED SELF INSURANCE FOR EMPLOYEE HEALTH BENEFITS

PROPOSAL DUE DATE: **APRIL 23, 2004** AT 3:00 P.M. MST

Pre-Proposal Conference: Thursday March 25, 1:00 P.M.

ADOA Building
100 North 15th Avenue, Room 300
Phoenix, AZ 85007

In accordance with A.R.S. § 41-2534, competitive sealed proposals for the materials or services specified will be received by the State Procurement Office at 100 N. 15th Ave, Suite 104, Phoenix, until the time and date cited. Proposals received by the correct time and date will be opened and the name of each offeror will be publicly read. **Proposals must be in the actual possession of the State on or prior to the time and date and at the location indicated above. Late proposals will not be considered.**

Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the appropriate Procurement Agency. Requests should be made as early as possible to allow time to arrange the accommodation. A person requiring special accommodations may contact the solicitation contact person responsible for this procurement as identified above.

INFORMATIONAL DATA LIBRARY (LIBRARY) – CONTACT Steve.Alleman@ad.state.az.us for password and access to the LIBRARY website.

PLEASE INCLUDE RFP# AD040404 ON ALL CORRESPONDENCE

OFFERORS ARE STRONGLY ENCOURAGED TO CAREFULLY READ THE ENTIRE SOLICITATION.

Offer and Acceptance

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OFFER

TO THE STATE OF ARIZONA:

The Undersigned hereby offers and agrees to furnish the material, service or construction in compliance with all terms, conditions, specifications and amendments in the Solicitation and any written exceptions in the offer. Signature also certifies Small Business status.

Arizona Transaction (Sales) Privilege Tax License No.:

_____

Federal Employer Identification No.:

_____ _____ _____

For clarification of this offer, contact:

Name: _____

Phone: _____

Fax: _____

_____
Company Name

_____
Address

_____
City State Zip

_____
Signature of Person Authorized to Sign Offer DATE

_____
Printed Name

_____
Title

CERTIFICATION

By signature in the Offer section above, the OFFEROR certifies:

1. The submission of the offer did not involve collusion or other anti-competitive practices.
2. The OFFEROR shall not discriminate against any employee or applicant for employment in violation of Federal Executive Order 11246, State Executive Order 75.5 or A.R.S. §§ 41-1461 through 1465.
3. The OFFEROR has not given, offered to give, nor intends to give at any time hereafter any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant in connection with the submitted offer. Failure to provide a valid signature affirming the stipulations required by this clause may result in rejection of the offer. Signing the offer with a false statement may void the offer, any resulting contract and may be subject to legal remedies provided by law.
4. **The offeror certifies that the above referenced organization ___is/___is not a small business with less than 100 employees or has gross revenues of $4 million or less.**

ACCEPTANCE OF OFFER

The Offer is hereby accepted.

The Contractor is now bound to sell the materials or services listed by the attached contract and based upon the solicitation, including all terms, conditions, specifications, amendments, etc., and the Contractor's Offer as accepted by the State.

This contract shall henceforth be referred to as Contract No. _____. The Contractor has been cautioned not to commence any billable work or to provide any material or service under this contract until Contractor receives purchase order, contact release document or written notice to proceed.

State of Arizona
Awarded this _____ **day of** _____ **20** ____

_____
Procurement Officer

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FINANCIAL PROPOSAL

1. INSTRUCTIONS

2. The financial section of your RFP response should follow the format as outlined in this section.

As you prepare the financial analysis for ADOA, please use the attached excel spreadsheet, Financials.xls to complete the financial calculation. It is very important you follow the provided format. If there is a need to deviate from this format, please give a detailed explanation of the change and make sure the information is provided in a clear and logical format and that it provides all of the information requested.

In preparing your financial response, make sure to include all assumptions. ADOA shall not incur any additional fees throughout the duration of the contract if not identified in the financial response.

- Provide all fees on a per-employee-per-month (PEPM) basis.
- The proposed plan designs are included in the Data Library.
- Provide two quotes:
  - 1a) On a bundled basis assuming prescription drugs and stop loss are carved in
  - 1b) On a bundled basis assuming prescription drugs and stop loss are carved out
- Do not include commissions in your fees.
- Three-year fee guarantees/commitments are required for all services.
- Please quote on the EPO and PPO separately.

3. REQUESTED SERVICES

The following services are required as part of your base fee quote.

Claims Administration	Included in Quoted Fees	Not Included in Quoted Fees Additional Cost
1. Claim Forms		
2. ID Cards		
3. Eligibility Maintenance		
4. Periodic Meetings with Client (plus training of staff)		
5. Legal Support		
6. Underwriting and Actuarial Support		
7. ERISA Required Reports		
8. Conversion Privilege		
9. Fiduciary		
10. Subrogation		
11. Plan Document (client specific)		
12. SPDs/Booklets (client specific)		

Pricing Schedule

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Claims Administration	Included in Quoted Fees	Not Included in Quoted Fees Additional Cost
13. Employee Communication Materials (please specify)		
14. Claim Adjudication and Payment (including verification of eligibility)		
15. Transfer of Historical Claim Data (from prior carrier)		
16. Coordination of Benefits (COB) and Subrogation		
Other Available Services:		

URUM	Included in Quoted Fees	Not Included in Quoted Fees Additional Cost
1. Preadmission Certification		
2. Concurrent Review		
3. Discharge Planning		
4. Outpatient Surgery		
5. Behavioral Health		
6. Focused Psychiatric		
7. Disease Management		
8. Health Line/On-Call Nurse		
9. Fiduciary Liability		
10. Second Surgical Opinion		
11. Large Case		
12. Employee Communication Materials (please specify)		
Other Available Services:		

4. REQUESTED SERVICES — PHARMACY

The following services are required as part of your base fee quote. Please note any discrepancies below.

Retail Broad Network — Financial Component

	2005	2006	2007
1. Brand AWP Discount (Broad)			
2. Generic MAC Discount (Broad)			
3. Guaranteed Overall Effective Generic Discount (Broad)			
4. Dispensing Fee (Broad)			
5. Administrative Fee (Retail) - applicable to all proposed networks			

Retail Network — Select Network Proposals

	2005	2006	2007
1. Brand AWP Discount (Select)			
2. Generic MAC Discount (Select)			
3. Guaranteed Overall Effective Generic Discount (Select)			
4. Dispensing Fee (Select)			

Retail Network — Preferred Network Proposals

	2005	2006	2007
1. Brand AWP Discount (Preferred)			
2. Generic MAC Discount (Preferred)			
3. Guaranteed Overall Effective Generic Discount (Preferred)			
4. Dispensing Fee (Preferred)			

Retail Network — Mail Order Proposals

	2005	2006	2007
1. Brand AWP Discount (Mail)			
2. Generic AWP Discount (Mail)			
3. Dispensing Fee (Mail)			
4. Administrative Fee (Mail)			

Rebates

	2005	2006	2007
1. Retail (per claim)			
2. Mail (per claim)			
3. Flat, Minimum, or Escalating Guarantee			
4. Sharing Arrangement			

Implementation Credit

	2005	2006	2007
1. Implementation Credit			

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Additional Pricing Statistics

	2005	2006	2007
1. Paper Claim Fee			
2. ID Cards			
- Initial			
- Replacement			
3. Member Call Center Service			
4. Toll-Free Number			
5. Specialty Pharmacy			
6. On-line Reporting Tool			

5. FEES

REGION A (MARICOPA, PINAL, AND GILA COUNTIES)

1.a. EPO — Stop Loss and PBM Carved-In

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
▪ $200,000			
▪ $300,000			
▪ $400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

1.b. EPO — Stop Loss and PBM Carved-Out

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

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2.a. PPO — Stop Loss and PBM Carved-In

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.b. PPO — Stop Loss and PBM Carved-Out

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

6. REGION B (PIMA AND SANTA CRUZ COUNTIES)

1.a. EPO — Stop Loss and PBM Carved-In

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

1.b. EPO — Stop Loss and PBM Carved-Out

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			

EPO Plan	2005	2006	2007
Other Fees (PEPM)			
Total Fees (PEPM)			

2.a. PPO — Stop Loss and PBM Carved-In

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.b. PPO — Stop Loss and PBM Carved-Out

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

7. REGION C (Yuma, La Paz, and Mohave Counties)

1.a. EPO — Stop Loss and PBM Carved-In

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

1.b. EPO — Stop Loss and PBM Carved-Out

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			

EPO Plan	2005	2006	2007
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.a. PPO — Stop Loss and PBM Carved-In

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.b. PPO — Stop Loss and PBM Carved-Out

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

8. REGION D (Yavapai, Coconino, Navajo, and Apache Counties)

1.a. EPO — Stop Loss and PBM Carved-In

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
▪ $200,000			
▪ $300,000			
▪ $400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

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1.b. EPO — Stop Loss and PBM Carved-Out

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.a. PPO — Stop Loss and PBM Carved-In

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.b. PPO — Stop Loss and PBM Carved-Out

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

9. REGION E (Greenlee, Graham, and Cochise Counties)

1.a. EPO — Stop Loss and PBM Carved-In

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
$200,000			
$300,000			
$400,000			
Other Fees (PEPM)			

EPO Plan	2005	2006	2007
Total Fees (PEPM)			

1.b. EPO — Stop Loss and PBM Carved-Out

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.a. PPO — Stop Loss and PBM Carved-In

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.b. PPO — Stop Loss and PBM Carved-Out

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

10. REGION F (Consists of the additional 49 states and all other countries)

1.a. EPO — Stop Loss and PBM Carved-In

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

1.b. EPO — Stop Loss and PBM Carved-Out

EPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.a. PPO — Stop Loss and PBM Carved-In

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
UR/UM (PEPM)			
Disease Management (PEPM)			
Pharmacy (PEPM)			
Stop Loss (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

2.b. PPO — Stop Loss and PBM Carved-Out

PPO Plan	2005	2006	2007
ASO Fee (PEPM)			
Network Access Fee (PEPM)			
Disease Management (PEPM)			
UR/UM (PEPM)			
Other Fees (PEPM)			
Total Fees (PEPM)			

11. FEE FINANCIAL CAVEATS AND ASSUMPTIONS

A = agree D = agree with deviations N = no

	A	D	N
Quoted rates do not include commissions.	_____	_____	_____
Your rate/fee quotes in this RFP and future quotes assume that you will be responsible for all claims incurred through the term of the contract.	_____	_____	_____

Describe any rating caveats or assumptions associated with your quoted fees.
Please indicate any additional costs associated with administration of run-out claims, including the issuing of HIPAA certificates for terminated employees.
Please identify and detail any shared savings, discount, or re-pricing programs available to ADOA to lower the cost of non-network and out-of-area claims.

SCOPE OF WORK

The State of Arizona (the State) has established the Saguaro Health Insurance Program (Saguaro Plan) to provide group health, dental coverage, life insurance, flexible spending, vision coverage, short-term and long-term disability coverage for all State agencies, universities, boards, and commissions

1. INTRODUCTION AND BACKGROUND

1.1 The Arizona Department of Administration, ADOA, (Agency) is responsible for administering the Saguaro Health Insurance Plan.

1.2 Since 1982, the State has maintained one or more fully-insured Health Maintenance Organizations (HMO's) and an Indemnity/PPO plan. The State began the philosophical approach of managed competition in 1992 for its group health plans.

1.3 Of approximately 60,000 eligible employees, 51,000 choose to participate in the Saguaro Plan. There are 42,000 employees in the metropolitan areas of Maricopa and Pima Counties; 8,600 employees in the remaining 13 rural counties; and 140 reside out-of-state. Additionally, nearly 8,700 retirees remain in the program- 6,800 are in Maricopa and Pima Counties; 1,500 reside in the 13 rural counties; and 410 live out-of-state.

1.4 Effective October 1, 2001, the State transitioned to a single contract with CIGNA for fully insured statewide group health coverage. Current plans offered include an HMO in both Maricopa and Pima counties, a POS plan in Maricopa and Pima counties, and a PPO offered in all counties. Coverage is also afforded nationwide and internationally to:

1.4.1 Saguaro Program members temporarily working elsewhere; and

1.4.2 Saguaro Program members permanently living out-of-state and/or abroad; and

1.4.3 employee/retiree dependents attending school out-of-state, as long as:

1.4.3.1 The dependent's permanent address is the employee/retiree's residence; and dependent qualifies under the eligibility requirements.

2. PURPOSE

2.1 A.R.S. 38-651 allows the State to self-insure group health benefits for all eligible participants. Any reference to PPO or HMO for implementation after 10/1/2004, should assume self-insured equivalents.

2.2 At this time, the plan year for all coverage administered by the Agency begins October 1st of each year. Open enrollment periods are usually held during the months of August and September.

2.3 The Agency may use both an integrated and a non-integrated self-insured model for group health in order to accomplish the following goals:

2.3.1 Offer more network availability to Saguaro Program members.

2.3.2 Maintain greater flexibility over plan design from year to year;

2.3.3 Better manage healthcare costs and expenditures;

2.3.4 Gain greater control and access to claims and utilization data in order to make better policy decisions.

2.4 An integrated system is described as a "package" of services provided by the carrier. The Agency may elect to carve out stop loss or pharmacy from the integrated system. A non-integrated system is described as unbundled services purchased from independent

organizations providing specific services such as UR/UM, PBM, Network management, or stop loss.

2.5 This request is for an integrated plan with the option to carve out PBM or stop loss to be effective on 10/1/2004.

3. ELIGIBILITY/EFFECTIVE DATE

3.1 Eligible Employees (R2-5-416) All State and University employees, except those listed in Paragraph 3.3 and their eligible dependents as defined in Paragraphs 3.6 & 3.7 may participate in the Saguaro Program, if they comply with contractual requirements of the selected benefit plan.

3.2 Effective Date for Eligible Employees All eligible employees are eligible for coverage on:

- 3.2.1 The first day of the month following their recorded date of hire provided that enrollment has been received within the first thirty (30) days of employment; or
- 3.2.2 On the first day of the month following a change in employment status that qualifies the employee for benefits eligibility; or
- 3.2.3 On the date of a qualified life event as defined in Paragraph 3.16, provided that enrollment change has been made within thirty-one (31) days of the event; or
- 3.2.4 The beginning of the next coverage period after notification of a qualified life event as defined in Paragraph 3.16, provided that enrollment change has been made within thirty-one (31) days of the event; or
- 3.2.5 On the first day of each plan year provided enrollment change has been made during the designated open enrollment period.

3.3 Ineligible Employees (R2-5-416) The following categories of employees are not eligible to participate in the Saguaro Program.

- 3.3.1 Employees who work less than twenty (20) hours per week or less than forty (40) hours bi-weekly (unless reduction in hours is due to an approved leave covered under the FMLA);
- 3.3.2 Employees in temporary, emergency, or clerical pool positions;
- 3.3.3 Patients or inmates employed in State Agency institutions;
- 3.3.4 Non-State employee officers and enlisted personnel of the National Guard of Arizona;
- 3.3.5 Employees in positions established for rehabilitation purposes;
- 3.3.6 An employee of any state college or university;
  - 3.3.6.1 Who works fewer than twenty (20) hours per week or fewer than forty (40) hours biweekly; or
  - 3.3.6.2 Who is engaged to work for fewer than six (6) months; or
  - 3.3.6.3 For whom contributions are not made to a state retirement plan of this State. This disqualification does not apply to a non-immigrant alien employee, an employee participating in medical residency training program, a retiree returning to work for the University, or a Cooperative Extension employee on federal assignment.

3.4 Eligibility exceptions (R2-5-416) Employees who are on an approved leave without pay may continue to participate in Saguaro Program under the conditions set forth in the rules and policies established by the Agency.

3.4.1 Employees on leave without pay due to industrial illness or injury (R2-5-405) may continue to participate in the medical, dental and vision plans for a maximum of six (6) consecutive months from the date of illness or injury by paying the employee contribution; and

3.4.1.1 May continue to participate in the basic, supplemental life and short-term disability insurance plans for a maximum of six (6) consecutive months from the date of illness or injury by paying the employee contribution; and

3.4.1.2 At the end of the six (6) month period, an employee who remains on leave without pay due to industrial illness or injury may continue to participate in the Saguaro Program by paying both the state and employee contributions.

3.4.2 Employees on medical leave without pay [non- industrial] (R2-5-413) or leave without pay for health-related reasons [non-industrial] (R2-4-413):

3.4.2.1 may continue to participate in the medical, dental & vision plans for a maximum of thirty (30) consecutive months after the incapacity began by paying both the state and employee contribution; and

3.4.2.2 May continue to participate in the basic, supplemental life and short-term disability insurance plans for a maximum of thirty (30) consecutive months from the date of illness or injury by paying the employee contribution.

3.4.3 Employees on an approved leave without pay for any other reason (R2-5-413):

3.4.3.1 May continue to participate in the medical, dental & vision plans for a maximum of six (6) consecutive months after the initial date of leave by paying both the state and employee contribution; and

3.4.3.2 May continue to participate in the basic, supplemental life and short-term disability insurance plans for a maximum of six (6) consecutive months from the date of illness or injury by paying the employee contribution.

3.4.4 Employees on any leave with or without pay that qualifies under the FMLA (Family and Medical Leave Act of 1993) (R2-5-412 & R2-5-416):

3.4.4.1 May continue to participate in the Saguaro Program for up to a maximum of the twelve (12) weeks of paid or unpaid leave in a twelve (12) month period.

3.4.4.2 During any portion of the twelve (12) week FMLA leave that becomes an unpaid leave,

3.4.4.3 The State will continue contributions for the employee on the same terms as prior to beginning the leave; and

3.4.4.4 The employee is responsible for the employee premium portion for all enrolled benefit elections at the beginning of the leave period.

3.4.5 Employees on military leave without pay (Guidelines developed in 2001 to comply with USERRA):

3.4.5.1 May continue to participate in all enrolled benefit elections for a maximum of six (6) consecutive months in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA) by paying both the state and employee contribution.

3.4.5.2 After the initial six (6) month period, medical, dental and vision coverage can be continued under COBRA up to a maximum of eighteen (18) months or for the period of service, whichever is shorter.

3.4.5.3 COBRA coverage application must be made:
3.4.5.3.1 within sixty (60) days of the date of COBRA notification; or
3.4.5.3.2 termination of original six (6) month enrollment period.

3.4.6 Termination of coverage while on any leave without pay status will occur at such time as:
3.4.6.1 The employee chooses to discontinue benefits at the initiation of a leave without pay period; or
3.4.6.2 The employee returns to work; or
3.4.6.3 The employee qualifies for Medicare benefits; or
3.4.6.4 The employee qualifies to participate in the Saguaro Program as an LTD recipient or retiree; or
3.4.6.5 The agency terminates employment; or
3.4.6.6 The agency separates the employee from service; or
3.4.6.7 Required premium payments are not made.

3.5 Eligibility Restrictions (policy)
3.5.1 An employee may not be covered under the Saguaro plan both as an employee and as a dependent for the same coverage.
3.5.2 If both a husband and a wife are eligible employees, dependent children can be covered under the Saguaro plan by either parent, but not by both parents.
3.5.2 In addition, an employee may not enroll their dependents without enrolling themselves in the Saguaro plan.

3.6 Eligible Dependents (R2-5-416) Eligible dependents shall include eligible employees, retirees, disabled employees or former elected officials:
3.6.1 Legal spouse as defined by the State of Arizona;
3.6.2 Unmarried natural children or legally adopted children (from the date of placement in the employee's home for the purpose of adoption) until their nineteenth (19th) birthday.
3.6.2.1 If the above mentioned children are out-of-state residents due to divorce or legal separation, they are eligible for coverage if services under the plan are available in the dependent's area of residence. If services are not available, only emergency services would be provided.
3.6.2.2 The following children under the age of nineteen (19) will also be considered as eligible dependents provided they reside with the employee in a normal parent-child relationship, and the employee or the member's spouse is legally responsible to provide medical care;
3.6.2.3 Stepchild(ren);
3.6.2.4 Lawfully placed foster child(ren) for whom coverage is not available through a state agency;
3.6.2.5 A child who is under the legal guardianship of the employee substantiated by a court order.
3.6.3 Unmarried children nineteen (19) years of age but less than twenty-five (25) years of age are eligible, provided they are a full-time student (as defined by the institution they are attending) at an accredited university, college, vocational or other institution of higher learning, and they are dependent upon the employee for principal financial support. If a dependent student has completed the semester prior to a summer recess and will return

to school the following semester, eligibility will continue through the summer recess. However, they are no longer an eligible dependent and coverage will cease:

3.6.3.1 at the end of the month in which they graduate; or

3.6.3.2 when they are not scheduled to return to school the semester following a recess; or

3.6.3.3 when the student drops out of school; or

3.6.3.4 is suspended from enrollment for any reason.

3.7 Disabled Dependents (R2-5-416 & Policy) An unmarried child who has reached the specified age limit as outlined in Paragraph 3.6.2 and 3.6.3 will continue to be eligible if the child is:

3.7.1 Incapable of self-support due to a mental or physical disability; and

3.7.2 Became so disabled prior to the attainment of age nineteen (19); and

3.7.3 The Saguaro plan is provided with proof of the child's disability and continued dependency within thirty-one (31) days prior to the termination of the child's eligibility. The Saguaro plan requires that the covered employee obtain a Physician's statement certifying the physical or mental handicap prior to approval and at intervals thereafter.

3.8 Newborn Dependents (Policy) Newborn dependents will be covered from the time of the birth for necessary medical care only if:

3.8.1 The employee is carrying dependent coverage on the date of the baby's birth [NOTE: "Routine" newborn charges incurred at a hospital at the time of birth and for the first 30 days of the child's life will be considered under the mother's coverage and paid as part of the mother's claims, whether or not dependent coverage is in effect]; or

3.8.2 Enrollment is received within thirty-one (31) days of the date of birth.

3.8.3 Dependent coverage for newborns is effective on the date of birth of the new dependent as defined in Paragraph 3.6.

3.9 Enrollment of Eligible Dependents (R2-5-416) An eligible employee, retiree, LTD participant or elected official may enroll eligible dependents:

3.9.1 at the time of the member's original enrollment; or

3.9.2 within thirty-one (31) days of a qualified life event as outlined in Paragraph 3.16; or

3.9.3 during the open enrollment period as defined by the Saguaro program.

3.10 Retiree and Disabled Employees Eligibility (R2-5-418) All State employees are eligible who have:

3.10.1 retired and are receiving a regular monthly income from a recognized retirement program of this State; or

3.10.2 started receiving monthly income benefits from a recognized long-term disability income insurance plan of this State; and

3.10.3 is a Saguaro Program member not in delinquent payment status; and

3.10.4 opted upon retirement or disability to enroll or continue enrollment in the Saguaro Program for active employees working for the State of Arizona; and

3.10.5 completed application for enrollment is received within the first 30 days after the effective date of retirement or the notification date of approval for disability income.

3.11 Effective date for Retiree and Disabled Employees (policy) All eligible retirees and disabled employees will be covered:

3.11.1 on the first (1st) or sixteenth (16th) day of the month following

3.11.1.1 their recorded date of retirement; or

3.11.1.2 approval date for disability income; or
3.11.1.3 upon active coverage termination date; or
3.11.1.4 the day after period of final premium payments under active coverage.

3.12 Former Elected Officials Eligibility (R2-5-419 and A.R.S. §38-651.01) A former elected official is eligible who:
3.12.1 has at least five years of credited service in the Elected Officials' Retirement Plan; and has been covered under the Saguaro Program, another group health or group health and accident plan while serving as an elected official; and
3.12.2 served as an elected official on or after January 1, 1983; and
3.12.3 application for enrollment is received within
3.12.3.1 thirty (30) days of leaving office; or
3.12.3.2 the first thirty (30) days after the effective date of retirement from the Elected Officials Retirement Plan (EORP); or
3.12.3.3 thirty (30) days of the notification date of approval for disability income.

3.13 Effective date for Former Elected Officials (R2-5-419) All eligible former elected officials will be covered:
3.13.1 on the first (1st) or sixteenth (16th) day of the month following:
3.13.1.1 their recorded date of retirement; or
3.13.1.2 approval date for disability income; or
3.13.1.3 upon active coverage termination date; or
3.13.1.4 the day after period of final premium payments under active coverage.

3.14 Medicare Eligibility (policy) A member who qualifies for Medicare benefits may participate in the Saguaro Program Medicare coordination plans if one is offered and the member can provide proof of enrollment in Medicare part A and Medicare part B.

3.15 Eligibility for extended coverage (R2-5-418 & R2-5-419 & R2-5-420)
3.15.1 Extended coverage will be granted to a covered member whose eligibility ceases due to certain qualifying life events to include but not limited to:
3.15.1.1 all COBRA eligibility events; or
3.15.1.2 agency approval of continued benefits after termination provided the agency commits to pay the employer portion of the premiums; or
3.15.1.3 Terminated LTD recipients for a maximum of 12 months after the date of termination of benefits; or
3.15.1.4 continuation of benefits under the State's Reduction in Force policies as outlined in A.R.S. §41-763.04.
3.15.2 Extended coverage will be granted to surviving spouses and/or dependents of:
3.15.2.1 Retired employees collecting pension from a recognized retirement system through the State (R2-5-418); or
3.15.2.2 Active employees eligible for normal retirement as defined by the retirement system the deceased member was enrolled in during employment (A.R.S. §38-651-01); or
3.15.2.3 Employees collecting income from a approved long-term disability provider with this State (R2-5-418); or
3.15.2.4 Public Safety Personnel Retirement System, Correctional Officers Retirement Plan, Elected Officials Retirement Plan and Option Retirement

Plan members whose survivors are eligible to collect a monthly annuity from the above mention retirement system (A.R.S. §38-782); or

3.15.2.5 Deceased elected officials who meet the qualifications for eligibility or would have met the qualifications upon completion of the term of office in which the deceased elected official was serving at the time of death (A.R.S. §38-651.01).

3.15.2.5.1 Provided the covered member, surviving spouse and/or dependents

3.15.2.5.2 Apply for coverage within six (6) months of the employees, retirees or LTD participants death; and

3.15.2.5.3 Are current members of the Saguaro plan at the time of the covered member's death; and

3.15.2.5.4 Maintain full premium payment for the coverage elected.

3.16 Qualified Life Event Changes to Enrollment (26 US Code 125, Internal Revenue Code of 1986): If a Saguaro program member has any of the following qualifying life events during the plan year, the plan member will be allowed to make a change in his/her coverage elections and/or list of eligible dependents in a non-open enrollment period in accordance with 26 US Code 125, Internal Revenue Code of 1986:

3.16.1 Events that change a member's legal marital status:

3.16.1.1 Marriage; or

3.16.1.2 Divorce; or

3.16.1.3 Legal separation; or

3.16.1.4 Annulment; or

3.16.1.5 Death of spouse.

3.16.2 Events that change a member's number of dependents, including the following:

3.16.2.1 Birth; or

3.16.2.2 Adoption; or

3.16.2.3 Placement for adoption; or

3.16.2.4 Court award of guardianship; or

3.16.2.5 Change in child custody that effects the dependents residence; or

3.16.2.6 Dependent marriage; or

3.16.2.7 Death of dependent child.

3.16.3 Any of the following events that change the employment status of the member, the member's spouse, or the member's dependent:

3.16.3.1 a termination or commencement of employment; or

3.16.3.2 a strike or lockout; or

3.16.3.3 a commencement of or return from an unpaid leave of absence; or

3.16.3.4 a change in work site that affects or changes plan availability; or

3.16.3.5 changes in employment status of the member, member's spouse or member's dependent, member's spouse or member's dependent becomes (or cease to be) eligible under the Saguaro program or other benefit plan.

3.16.4 Events that cause a members dependent to satisfy or cease to satisfy eligibility requirements for coverage as outlined in Paragraph 3.6 & 3.7, such as:

3.16.4.1 Attainment of age; or
3.16.4.2 Student status; or
3.16.4.3. Any other reason provided by the definition of an eligible dependent.

3.16.5 A change of residence that affects or changes plan availability;

3.16.6 Judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order [QMCSO] as defined in Paragraph 609 of the Employee Retirement Income Security Act of 1974 (Public Law 93-406 (88 Stat. 829)) that requires accident or health coverage for a member's child or for a foster child who is a dependent of the member.

3.16.7 Entitlement or cancellation of coverage under Medicare or Medicaid (AHCCCS) in accordance with Part A or Part B of Title XVIII of the Social Security Act (Medicare) (Public Law 89-97 (79 Stat. 291) or Title XIX of the Social Security Act (Medicaid) (Public Law 89-97) (79 Stat. 343).

3.16.8 Significant cost increases of the benefits to all members in a given geographic area or plan.

3.16.9 Significant changes in the benefits offered
3.16.9.1 significant loss of providers to all members in a geographic area or plan; or
3.16.9.2 reduction in coverage offered; or
3.16.9.3 elimination of benefit option; or
3.16.9.4 addition of a benefit option.

3.16.10 Changes in spouse's, former spouse's and/or dependent's coverage through his/her employer which affects the eligibility or allows the enrollment in a benefits program.

3.17 Rules for Qualified Life Event Changes Mid-year changes can be made under the Saguaro plan provided:

3.17.1 Any changes to be made to the benefit elections must be:
3.17.1.1 necessary, appropriate and consistent with the qualified life event listed in Paragraph 3.15; and
3.17.1.2 meet the guidelines of 26 US Code 125, Internal Revenue Code of 1986; and
3.17.1.3 are approved by the plan administrator or its designee; and
3.17.1.4 the member provides all required supporting documentation for the requested change (A.R.S. §38-651 (G); and
3.17.1.5 the plan is notified within thirty-one (31) days of the qualifying life event (with exception of mandatory event changes resulting in reduction of coverage [see Paragraph 3.17.3]).

3.17.2 If the above rules are not met the eligible employee and/or dependent must wait until the next designated open enrollment period to make any changes to coverage.

3.17.3 The following stipulations apply to reduction in coverage that are mandatory in nature such as removal of dependents due to death, divorce, annulment, legal separation, dependent ceases to be eligible, custody changes and court orders.
3.17.3.1 Changes will be allowed if notification is after the thirty-one (31) day notification period; and
3.17.3.2 Premiums that have been paid during the extended coverage period will not be refunded; and

3.17.3.3 Changes in coverage will become effective at the beginning of the next coverage period after receipt of the change.

4. SPECIAL ENROLLMENT SITUATIONS

4.1 If a contracted medical network, PPO, HMO, or any integrated self-insured equivalents are impacted by a significant reduction in providers or facilities to the extent they may no longer be able to perform to the requirements of this contract, the State shall be notified in writing at least 90 days in advance. The State shall determine from the facts and circumstances what would constitute a significant change. At the State's option, members participating in such a plan may be offered an opportunity to disenroll/enroll and select another provider. All contractors servicing the area shall agree to accept enrollees seeking a new provider under such conditions.

4.2 The State shall be the final decisive authority on all special, unanticipated, unusual, or new enrollment determinations when new legislation or policy changes occur throughout the plan year. This may include financial and program impact to State employees, University employees, retirees, any dependents, surviving spouses, ADOA, or the Health Insurance Trust Fund.

5. TERMINATION OF COVERAGE

5.1 Enrolled employee, retiree, long-term disability participants, surviving spouses and/or dependents coverage under this plan shall terminate at 11:59 P.M. on the last day of the period covered by the last premium payment upon:

- 5.1.1 Termination of the eligible employee's employment; or
- 5.1.2 Death of the member; or
- 5.1.3 Any member ceases to meet the eligibility requirements for the plan; or
- 5.1.4 Maximum time allowance for coverage has ceased; or
- 5.1.5 Retirees that opt to decline the Saguaro program effective the first (1st) of the month following notification of intent to cancel; or
- 5.1.6 An active employee is in a leave without pay status and becomes eligible for coverage under another plan (retiree, LTD, or Medicare, etc.); or
- 5.1.7 Non-payment of the required contributions; or
- 5.1.8 The plan is discontinued with respect to the employer; or
- 5.1.9 The plan is discontinued with respect to the class of employee to which such employee belongs; or
- 5.1.10 The fund or trust terminates; or
- 5.1.11 The date the eligible employee voluntarily elects to be terminated from the plan due to:
  - 5.1.11.1 Open enrollment elections; or
  - 5.1.11.2 Qualifying life event change; or
  - 5.1.11.3 Commencement of a Leave without Pay period.

5.2 Dependent coverage under this plan shall terminate at 11:59 pm on the last day of the period covered by the last premium payment upon:

- 5.2.1 Termination of the eligible employee's employment; or
- 5.2.2 The last contribution for dependent coverage; or
- 5.2.3 Termination of any or all dependent coverage under the plan; or
- 5.2.4 Dependent status change in which he/she ceases to be an eligible dependent under this plan; or

5.2.5 The dependent becomes eligible for coverage as an employee through the Saguaro Program.

6. PUBLIC ENTITY PARTICIPATION (OTHER JURISDICTIONAL USE OF ADOA ADMINISTERED HEALTH PLANS)

6.1 Arizona Revised Statutes (A.R.S. 38-656) allows "any school district in this state that meets the requirements of section 15-388, a charter school in this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 to participate in the health" insurance program.

6.2 Public entities shall comply with the following requirements:

6.2.1 School districts must have 500 or fewer employees.

6.2.2 Public entities must notify the Agency of their intent to join the health insurance program by the required date established by the Agency.

6.2.3 The entity must mirror the plan design, contribution strategy, and eligibility requirements as the State.

6.2.4 The entity shall not offer any other health plans to their employees.

6.2.5 The entity must participate in the health insurance program for a minimum of 2 plan years.

6.2.6 The entity must agree to pay any required administrative costs associated with their participation to include open enrollment costs, administrative services, actuarial/billing services, consulting fees, and all other services identified by the Agency.

7. RESERVED

8. MINIMUM BENEFITS AND TRANSITIONAL CARE

8.1 Transitional care shall be a covered benefit under the State's medical program as identified in the Summary Plan Document produced by the prior fully-insured carrier and any existing fully-insured contract.

8.2 Transitional care for medical care is defined as assistance to members of the State's plan (employees or retirees and their eligible dependents) for transition of care from a skilled nursing facility to home health, another long term care facility, and others as determined by the State to the extent benefits are exhausted or care is no longer determined medically necessary by a certified or licensed medical provider.

8.3 The Contractor shall assist in this process by working with the facility's social worker/discharge planner to evaluate the patient's needs and possible alternatives, as well as assisting the member in completion of paper work necessary for qualifying for state, federal or other programs.

8.4 Contractors, who consider this part of their concurrent review/discharge planning procedures, shall also meet the above guidelines. Questions received from program participants/family regarding health transitional care issues, shall be referred to the Contractor.

8.5 The Contractor shall furnish to the Agency the name, title and phone number of two individuals who will coordinate and assure prompt resolution of transitional issues. The Agency shall be notified with any changes to this information within 24 hours of any update.

8.6 The Agency shall be the final authority in determining the final disposition of transitional care issues.

9. USE OF NON-NETWORK PROVIDERS FOR PLAN PARTICIPANTS

9.1 The Contractor is responsible for the delivery and payment for all required benefits and services. When the contractor or any of its providers arranges for services that are not covered in the Contract, Summary Plan Document, or providers outside of the Agency's contracted medical networks, the member's financial liability is limited to the amount the member would have had to pay had the service been rendered by a Contractor provider. The cost of the service beyond the usual plan member liability shall be the Contractor's responsibility. Balance billing is prohibited.

10. GENERAL REQUIREMENTS

10.1 The Contractor shall provide services to all eligible employees, retirees, and dependents as determined by the State. Participation in the program by employees and retirees is 100% voluntary and there shall be no minimum enrollment requirements.

10.2 The Contractor shall maintain identical eligibility requirements and continued coverage provisions as the State. The Arizona Department of Administration will be the final authority on employee, dependent or retiree eligibility.

10.3 The Contractor shall provide services or coverage for all benefits from the effective date of the Plan Year. No employee, dependent, or retiree shall suffer loss of any coverage due to any change in plan administrator(s) other than by a change in plan design, as determined by the Agency. No employee, retiree, or dependent shall lose benefits because of administrator(s), contractor, or transition issues.

10.4 All currently eligible employees, dependents, and retirees shall be able to elect new coverage during open enrollment each year, without the burden of pre-existing condition limitations. A standard 90/90/12 pre-existing condition limitation is applicable for any indemnity/PPO plan offered to new employee or any employee or dependent not previously covered by the State's plan in accordance with HIPAA guidelines. State retirees enrolled in the plan or newly retiring State employees shall be eligible to participate in this plan from their initial date of retirement.

10.5 The pre-existing condition limitation shall not apply if the participant satisfies either of the following criteria: (a) 90-day period which ends while a person is insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a physician in connection with that injury or illness; or (b) one year period during which a person is continuously insured for benefits. 90/90/12 means that 90 days prior to effective date would be treatment free or any 90-day period, which is treatment free during the first year or one full year of coverage.

10.6 All services provided shall be quality services, meeting or exceeding medical/provider industry standards. The Contractor shall immediately take corrective steps when services do not meet such standards, if standards are inappropriate, undesirable, and/or poor quality services as identified by the Agency. Corrective measures taken to ensure Agency quality standards, reporting standards or performance standards will be provided at no additional cost to the Agency through administrative fees, service fees or hidden charges.

10.7 The Contractor will perform services reasonably required by the State to include, but not limited to: Agency review and approval of draft and final plan materials; summary plan documents; cooperation with outside consultants, contractors (e.g. UR, Network contractors, etc.) and

auditors; and any other reasonably required services to ensure adequate performance and delivery of the Agency health insurance program.

10.8 The Contractor shall provide a dedicated and responsive account management team, including network development support, focused on proactive and efficient management of any and all provider networks.

10.9 The Contractor will provide an Agency specific member website to include, but not limited to, review of membership information; provider directory; review of authorization status; general plan information and program updates; and other information directed by the Agency.

10.10 The Contractor will update the provider directory on a frequent and necessary basis, in agreement with the Agency's established time-frame.

11. COBRA ADMINISTRATION

11.1 The Agency will send the initial notice to terminated employees following a qualified event.

11.2 The Contractor shall maintain all regulatory COBRA compliance processes and procedures.

12. SURVEYS

12.1 The Agency will conduct a member satisfaction survey for all services provided by the contractor as well as the contracted medical service. The survey will be conducted quarterly during the plan year. A list of random members to be surveyed will be selected from current members based on services provided. Such surveys shall be for the purpose of assessing member satisfaction with services performed by the Contractor.

12.2 The Agency may publish the results of surveys for distribution among State plan members, the legislature, or the media if requested

13. CURRENT FUNDING

13.1 The current HMO contract is fully insured community rated.

13.2 The current PPO and POS contract is fully insured.

14. PLAN / PROGRAM DESIGN (SCHEDULE OF BENEFITS)

14.1 The current Plan Design of group health and dental benefits is included in the Data Library.

14.2 The following are the group medical plans for Saguaro Program members (see Data Library for Plan Design information):

14.2.1 Medical plans include an EPO plan, a PPO plan or any combination of both or each.

14.3 Each Contractor may supply services to all, any, or individual network regions at the Agency's discretion.

14.4 The network regions are as follows:

14.4.1 Central region (A) consists of Maricopa, Pinal and Gila counties;

14.4.2 Southern region (B) consists of Pima and Santa Cruz counties;

14.4.3 Western region (C) consists of Yuma, La Paz and Mohave counties;

14.4.4 Northern region (D) consists of Yavapai, Coconino, Navajo and Apache counties;

14.4.5 Southeast region (E) consists of Greenlee, Graham and Cochise counties;

14.4.6 Out-of-state region (F) consists of the additional 49 states and all other countries (nationwide and worldwide coverage).

15. CONTRIBUTION STRATEGY

15.1 Any contribution strategy utilized by the State is subject to available funds and review by the Joint Legislative Budget Committee pursuant to A.R.S. 38-658.

15.2 The current group health contribution strategy is available in the Enrollment Historical Data Library. Historically, the PPO/POS plans in Regions 1 and 2 have attracted more retirees and have an older demographic mix. The State will review the demographic mix of proposed plans to determine if additional adjustments will be required. See paragraph 35 of Special Terms and Conditions.

15.3 The State may entertain alternative strategies on an annual basis based on funding, enrollment, proposed programs and network availability.

16. DATA RECONCILITATION AND TRANSFER REQUIREMENTS

16.1 Contractor shall provide weekly full reconciliation file for eligibility purposes to include all data elements captured by the contractor on the weekly transmission of enrollment data. As requested, this data shall be made available at additional times through the File Transfer Process (FTP).

16.2 Contractor shall provide the Agency at a minimum a weekly full file of all data elements captures in transmission of claims information, both paid and unpaid to any party on behalf of or as directed.

16.3 Monthly financial reconciliation of enrollment and claims is required. The data elements are defined as any data element captured for the purpose of plan administration. The file shall be provided upon request and transmitted through an FTP process.

16.4 The specific data elements to be captured and transmitted shall be mutually agreed upon prior to the beginning of the plan year. Any data transmitted shall be through an FTP process.

16.5 Provide monthly a full electronic file of all enrollment and eligibility data elements as well as all data elements captured in claim processing. This information shall provided upon request and the data elements shall be mutually determined prior to the start of the plan year.

16.6 The enrollment and eligibility records shall be updated monthly based on the findings of the reconciliation process.

17. CLAIMS ADMINISTRATION

17.1 Contractor is required to perform all usual services incident to the settlement of claims in accordance with plan provisions, including but not limited to the provisions of appropriate and authorized forms, adjudication, medical review, records retention, check and EOB issuance, resolution of claimant inquiries, payment discrepancies, possible coordination with independent stop loss carrier and PBM, and claim appeal procedures.

17.2 Contractor is to create, provide, print, and maintain easy-to-read universal claim forms and EOBs approved by the Agency. All EOB's will be in accordance with general industry standards; contain all necessary coding; clear and concise explanations; including any language at the request of the Arizona Department of Administration.

17.3 All group health claims shall be paid in a timely manner pursuant to Arizona Department of Administration standards. Claims administration shall meet all performance standards for coding accuracy, financial accuracy and timeliness. The claims system shall have the capability to verify eligibility; verify eligible services; detect fraud; track information in various categories and formats; and determine benefits payable and issue payment (35-342).

17.4 The Contractor shall provide the following administrative services for the health program pursuant to this contract:

17.4.1 Creating and maintaining claims files.

17.4.2 Evaluating claims to determine if they have been properly filed; advising claimants in meeting the requirements for additional information; and proper completion of claim forms.

17.4.3 Computing all benefits due in accordance with current benefit plan document, State rule or statute, and/or documentation.

17.4.4 Appropriate and necessary coding (e.g. ICD9, CPT4, etc.)

17.4.5 Precertification requirement coordination.

17.4.6 Issuing drafts to the person or assignee entitled thereto (if applicable).

17.4.7 Tracking and processing of deductibles, copays, out-of-pocket maximums, lifetime maximums, etc.

17.4.8 Discussing claims, where appropriate, with the Agency, plan physicians, medical providers, dentists, and other providers of service.

17.4.9 Obtaining and furnishing information regarding coordination of benefits, stop loss insurance, and pharmacy benefits.

17.4.10 Applying claims control procedures necessary for the effective administration of the plan. These procedures may include Reasonable and Customary fee profiles based on HIAA or MDR data using the 90th percentile.

17.4.11 Handling any Medicare issues, Medicare lien issues or any CMS compliance requirements necessary.

17.4.12 Investigating claims in which any charges appear higher than usual. Timely notification to participants of delayed claim payments which are caused by the presence of duplicate coverage or an error of omission in claim payment documentation.

17.4.13 Verifying eligibility to provider of service through information provided by the Agency.

17.4.14 Establishment of dedicated customer service and claim units for the Agency.

17.4.15 The Contractor shall have the ability to accept all overflow calls from the Agency during and throughout the Agency's normal business hours.

17.4.16 The Contractor shall furnish, at the Agency's request, up to four (4) full time customer service representatives at the Agency's place of business in Phoenix, Arizona. The Agency may provide office space, furniture, equipment as necessary (with the exception of a personal computer for Contractor processing, which will be the responsibility of the Contractor.)

17.4.17 The Contractor shall provide a toll-free telephone line for claim inquiries staffed for answering inquiries at a minimum from 7:00 a.m. to 6:00 p.m. Arizona time, Monday through Friday, exclusive of State holidays. Extended hours will be preferable. Such toll-free number shall be on any and all claim forms, correspondence, and ID cards for easy access and usage by the employee, retiree or dependents.

17.4.18 Single front-end toll-free 800 telephone number with touch-tone routing (if necessary) for member services to respond to requests regarding provider participation and acceptance of new patients, provider locations, and complaints about provider practices and services.

17.4.19 A voice response system (if necessary) with a user-friendly menu that customers find easy to understand.
17.4.20 Customer service representatives that can speak Spanish fluently.
17.4.21 Establishment of quality assurance standards and control mechanism for assurance of compliance with such standards.
17.4.22 Print checks or drafts and corresponding explanation of benefits.
17.4.23 Request wire transfer or other agreed upon financial transfer of funds weekly from the designated the Agency method to fund claim payments.
17.4.24 Respond within one (1) working day to any inquiry from the Agency Benefits Supervisor, the Agency Benefits Manager, or designated staff regarding the disposition of pending claim.
17.4.25 Maintain, track, and notify the Agency within the designated time-frame of all claims or claimants that approach the notification requirements as identified for the Agency's stop-loss carrier for any conditions, diagnosis, or claim payments that cross the threshold for stop-loss carrier notification. The Contractor is to contact the stop-loss carrier and follow all requirements for appropriate claim notification.
17.4.26 Track and resolve all duplicate claims received, paid, or adjudicated.
17.4.27 Any and all claim reviews- alerts through the claims payment system, claim reports, or in person- as identified by the Agency for claim payment threshold, out-of-state claims filed for in-state members, claimant thresholds, unusual claims received, or identified parameters associated with financial management of claim payments.
17.4.28 Provide detailed cost and utilization statistics as required by the Agency.

18. CLAIMS SYSTEM

18.1 The Contractor's claim payment system shall be capable of maintaining on-line data and regular identified reporting submittal for the effective administration and adjudication of claims, including but not limited to the following:

18.1.1 Eligibility (e.g., employee, retiree, dependent, COBRA, effective date, termination date).
18.1.2 Tracking and accumulation of deductibles and coinsurance maximums (annual & lifetime).
18.1.3 Ability to accept the transfer of current data files including deductibles and annual and lifetime maximums.
18.1.4 Coding (e.g. ADA, CPT, CMS codes).
18.1.5 Creation of a claim file for each claim.
18.1.6 Patient identification.
18.1.7 Place of service.
18.1.8 Coordination of benefits.
18.1.9 Duplicate claim administration.
18.1.10 Applicable provider discounts.
18.1.11 UCR allowance.
18.1.12 Incurred date.
18.1.13 Claim Paid Date.

18.2 The Contractor shall work with and assist the Agency in coordinating eligibility, claims; financial data through multiple enrollment systems; multiple payroll/premium systems between, to and from multiple Plan contractors. All eligibility and claims data will be transmitted on a mutually agreed upon schedule to maximize program efficiency and reduce any negative impact to the management of the Saguaro Program.

18.3 Upon determination and identification of system problems, programming problems, or data transfer problems, the Contractor shall notify the Agency immediately upon identification of issues. The Contractor shall correct any problems immediately or as soon as possible, including but is not limited to nights, weekends, and holidays, to minimize any negative impact to employee, retirees, or dependents, and to maintain continual operation of the Saguaro Program.

19. CLAIM DENIAL

19.1 The Contractor shall notify claimants within 30 days of date of processing claims of denials or a reduction in claim payments and the specific reasons. If requested by the Agency, and in accordance with established procedures, the contractor shall provide copies of all relevant correspondence regarding each claim rejection/reduction to the Agency.

19.2 The Contractor shall notify the claimants by mail and enclose application and explanation of the appeals process.

20. CLAIM APPEALS

20.1 When a claim has been denied, or paid in part, the member shall have the ability to file an "appeal". The Contractor shall maintain and comply with the established claim appeal process in compliance with any and all state and federal statutes as applicable to the plan. The procedure shall be designed to fairly and expeditiously resolve the claims appeal related to the member.

20.2 The Contractor shall also inform the agency in writing of any 2nd level appeal that is declined. The Contractor shall include all information pertaining to the appeal.

20.3 The Contractor shall perform any processes developed or requested to expeditiously resolve issues, including improved language in any correspondence, modification of claim payment procedures, or any identified processes that may reduce the volume of complaints, grievances, and appeals from the initial receipt of same to elevation of issue.

21. MEMBER GRIEVANCE AND APPEALS PROCEDURES AND RESOLUTION REQUIREMENTS

21.2 The Contractor shall institute a procedure for responding to and resolving enrollee complaints, disputes, and appeals regarding the problems with provider access, request for change of providers, and other matters concerning quality of care. The Contractor shall inform each enrollee concerning the availability of the Agency's dispute resolution process and provide each enrollee with forms for problem reporting and resolution. The Contractor shall respond to all complaints, disputes, and appeals promptly, according to time standards established by Agency. In general, disputes about medical treatment should be resolved within seven (7) days after the complaint is filed. The Contractor shall work with, agree to, and implement the design and execution of the dispute resolution process with Agency.

21.3 The member dispute resolution process shall be designed to fairly and expeditiously resolve problems related to all issues of care, and access to care. The Contractor shall maintain a record of all complaints from active employees, retirees, and dependents and shall provide same to the

Agency pursuant to agreed upon terms, within 10 business days of the initial request, or other terms in this contract. Such record shall include all correspondence relating to and disposition of the complaint.

21.4 The Contractor shall provide and identify one key employee to communicate with, cooperate with, and maintain a working relationship with the identified Agency Grievance and Appeals Ombudsman, for the purpose of timely communication and coordination with employees, retirees, and their dependents.

21.5 The Agency will be solely responsible for any and all complaints, issues, disputes, and appeals related to plan enrollment, member eligibility, payroll deduction issues, direct-pay premium issues, and retirement check issues related to payment of premium.

21.6 The Contractor shall provide all requested information to the Agency and other contracting entities to assist in the completion of the member Appeals process.

21.7 The Contractor shall comply with the Appeals process developed by the Agency.

22. AUDIT

22.1 The Agency reserves the right to audit the Contractor's claim payment and eligibility records with reasonable notice. The Agency shall select the auditor of its choice. The Contractor shall cooperate with the auditor(s) and waive any fees associated with obtaining access to the Agency's records.

22.2 The Agency may conduct an audit on a regular basis, up to once per quarter if deemed necessary by the Agency or at any time determined necessary during or after completion of the contract year.

22.3 The Agency may also audit the Contractor's records relating to specific performance standards as outlined. These shall include but are not limited to the following issues:

- 22.3.1 Eligibility
- 22.3.2 Customer service department
- 22.3.3 Claims administration in terms of processing accuracy, financial accuracy and timeliness
- 22.3.4 Appeals/grievance/problem resolution
- 22.3.5 Quality assurance

23. OPEN ENROLLMENT ACTIVITIES

23.1 The Contractor shall conduct an orderly transition for an implementation date of October 1st or the identified start date of each plan year.

23.2 The Contractor shall provide the necessary staff for plan transition and open enrollment. The Contractor shall comply with the following open enrollment procedures:

- 23.2.1 Open enrollment shall be the period announced by the Agency. The open enrollment shall allow employees to join the plan, members to change coverage, or to add or delete eligible dependents. Coverage is effective October 1st or the identified start date of each plan year. Open enrollment shall be conducted during the time and length specified by the Agency.
- 23.2.2 All identified State personnel, including benefits liaisons, University liaisons, or retiree liaisons shall be trained prior to open enrollment meetings.
- 23.2.3 The Contractor shall be furnished with a list of State personnel officers, benefits liaisons, University personnel, and retirement personnel and their addresses to

facilitate State contact prior to the annual open enrollment. The Agency shall furnish the Contractor with plan member name and address if requested.

23.2.4 The Contractor shall use employee mailing lists solely for the performance of the duties and tasks related to this contract. All enrollment/communication materials shall be sent to employees via First Class unless another class of mail is authorized by the Agency. The Contractor shall provide written assurance that address lists are considered confidential and the property of the Agency.

23.2.5 The Contractor shall provide sufficient knowledgeable personnel to attend all scheduled informational and enrollment meetings during all open enrollments. Such meetings shall be scheduled throughout the State of Arizona and may number between 50 and 300 meetings. The number of meetings will be determined based on the number of changes to the current program that will require additional education. The Contractor shall be responsible for brief presentations and answer all pertinent questions during these meetings.

23.2.6 The Contractor shall provide input and review of a summary description of all contracted plans.

23.2.7 The Contractor shall provide staffing, as appropriate, to perform administrative work as determined by the Agency.

23.2.8 The Contractor shall provide marketing and any open enrollment material as requested by the Agency at least 30 days prior to open enrollment or at a specified time designated by the Agency.

24. MEMBERSHIP MATERIALS

24.1 The Agency shall review and approve all material prior to distribution by the Contractor to any Saguaro Plan participants. The Contractor shall provide the following materials to each new enrollee within 30 days (except ID cards) of receipt of confirmation from the Agency:

24.1.1 Claim form preparation, printing, and all other related activities. The Contractor shall provide claims processing instructions which are clear and complete. The claim forms shall be approved by the Agency and identify the mailing address and toll free phone number for claims on the forms or a preaddressed claim envelope. If applicable, The Contractor shall provide on-line claims process procedures.

25. IDENTIFICATION CARDS

The contractor shall:

25.1 Provide identification within 15 days of receipt of confirmation by the Agency. All identification cards shall be sent to employees via First Class unless another class of mail is authorized by the Agency. Each subscriber shall receive one identification card for each plan member and dependent and cards shall be received by the effective date of coverage.

25.2 Accept the enrollment form as a temporary identification card, and shall provide health services and treatments as if the patient appeared on the “roster” and presented a valid identification card.

26. PLAN MEMBER, COMMUNICATION MATERIAL, ADVERTISEMENTS AND MARKETING MATERIAL

The contractor shall:

26.1 Submit copies of all member communication materials and promotional materials to the Agency. All such materials shall be approved in writing by Agency prior to submission to the Department of Insurance (DOI) for approval and their subsequent use in promoting the medical plan to eligible enrollees. Materials include, but are not limited to notification letters, error/correction letters, form letters for additions or changes to the network, newsletters, COBRA correspondence or any material distributed to 50 or more plan members.

26.2 Prepare and cover cost of design, production and mailing of all announcements, letters, notices, brochures, forms, and other supplies and services for US mail distribution to employee/retiree residences. Contractor shall provide customized member communication materials during transition and implementation activities. Communication materials include network transition pieces that seek to proactively notify members of provider election issues.

27. PUBLIC INFORMATION REQUESTS, MEDIA REQUESTS, PRESS RELEASES, OR OTHER PUBLIC COMMUNICATION

The contractor shall:

27.1 Notify the Agency within 24 hours of a receipt of a written public information request, written media request, or other public inquiry regarding the Agency benefit plan. The Contractor agrees that all responses will be approved by Agency prior to release or response of inquiry.

27.2 Agree that all telephone inquiries for public information are to be transferred to the Agency for response and resolution. Submit copies of all press releases pertaining to or having impact on the State, Agency or the Saguaro Program. All such releases shall be approved in writing by Agency prior to submission or response.

28 CLAIM PERFORMANCE STANDARDS

28.1 The Contractor shall meet the Performance Standards outlined in the Performance Guarantees Section.

28.2 Contractor shall be required to show proof of quality of service and responsiveness no less than quarterly to the Agency.

29. SYSTEM AND REPORTING REQUIREMENTS

29.1 Contractor shall to the following identified State list of data elements that shall be maintained by the Contractor to meet the Agency's claims review and reporting requirements. Although the data elements shown in the attachment are shown under individual categories, they shall be maintained as inter-related segments for each individual claim. While the list reflects current needs, capture of additional claim items may be required by the Agency. The Contractor shall maintain records in such a manner that allow reporting of claims submitted by providers.

29.2 The Contractor shall provide, on a regularly scheduled basis, no less frequently than quarterly or as requested by the Agency, a suitable tape or CD-ROM disk file containing detailed claim records in a format required by a contractual claims analysis company.

29.3. The Contractor shall produce a file no less frequently than quarterly for submission to any other contractor specified by the Agency at no additional charge to the Agency.

29.4 The Contractor shall submit monthly, quarterly, and annual reports as outlined in the Reporting Section. In addition to any reports not mentioned in the Reporting Section, the Agency expects the Contractor to provide the Agency with its standard utilization reporting package.

29.5 The Agency will request any and all reports at any time throughout the contract period to meet its needs based on plan adjustment, legislative inquiries, or fund review. The Contractor shall provide such reports as soon as possible upon receipt of the request.

29.6 All routine reports identified shall be broken down by plan, by participant, by claimant, by dollar amount, by date, or any other parameter identified for report analysis.

30. CONTRACT TERM COMPLETION/TRANSITION RESPONSIBILITIES

30.1 Upon completion of the contract term, Contractor shall provide to the Agency communications and data support for a successful transition to any new Contractor.

30.2 The Contractor shall provide any data, reports, files, or information that will assist the Agency in moving to any new Contractor and will allow for a seamless transition of medical care for State employees, retirees, dependents, or any Saguaro Program member to the new Contractor.

31. MEDICAL NETWORK GENERAL REQUIREMENTS

The contractor shall provide:

31.1 A medical provider network for active employees, COBRA participants, retirees, and their eligible dependents, enrolled in the State of Arizona Saguaro Benefit plan.

31.2 Contractor's network shall provide the members easy access to providers, including complete representation for rural and out-of-state employees.

31.3 Customer communications materials for use during transition and implementation periods, as well as for future network or program changes.

32. MEDICAL NETWORK SPECIFIC REQUIREMENTS

The contractor shall:

32.1 meet the Plan Design requirements as outlined in the Data Library. These changes shall be operational as of the implementation date. There shall be no associated costs with the design and implementation of these programs.

32.2 provide a network of physicians, hospitals, and any other health care providers in areas that State employees reside. In Maricopa and Pima counties, members shall have access to 2 open Primary Care Physicians (PCPs) within 5 miles of the member's residential ZIP Code and 1 hospital within 15 miles. In all other Arizona counties, members shall have access to 2 open Primary Care Physicians (PCPs) within 25 miles, and at least 1 hospital within the county. PCPs shall be defined as family practice, general practice, internal medicine and pediatric practice only.

32.3 provide a contracted monthly network access fee per enrolled employee.

32.4 provide customized participant communications, to include provider directories on-line for all networks accessible to members. Contractor must update/refresh the directory at a minimum of once a week and as directed. Hard copy provider directories shall be provided for open enrollment and as requested for members without internet access.

32.5 Contractor's customer service activities are to include, but are not limited to:

32.5.1 Contractor shall perform all initial credentialing, monitoring, and re-credentialing of network providers.

32.5.2 Contractor shall perform periodic on-site audits of participating providers as necessary (a minimum of 2 percent of network providers in Arizona will be required).

32.5.3 Contractor shall implement a process to monitor, by geographic area, member provider election submissions, delivery of network applications, credentialing process and outcomes. Resulting reports shall be provided to State quarterly.

32.6 Agency shall be notified 60 days prior to effective date of any significant network changes, as determined by the Agency, which affect State membership. If network change is unanticipated, The Agency shall be notified within 15 days of the date of the change.

32.6.1 Notification shall be sent, within 15 days of the date of the change, to all affected members for all Primary Care Provider terminations.

32.7 Contractor shall maintain auditing, management information, reporting and analysis records for the mutually agreed specified time.

32.8 The assigned medical director shall be an Arizona-licensed physician, responsible for high quality member medical services.

33. MEDICAL NETWORK PERFORMANCE STANDARDS

33.1 The Contractor shall meet the minimum performance standards as outlined in the Performance Guarantees Section.

33.2 Contractor shall be required to show proof of quality of service and responsiveness no less than quarterly to the Agency.

34. MEDICAL NETWORK MANAGEMENT

The contractor shall:

34.1 Notify the Agency within 24 hours of the closure or termination of any hospital, physician, or provider group. Contractor must notify the Agency with the number of members impacted due to group closures or terminations from network and distribute communication to the affected members as to their options and alternative providers or services. Notification must be sent to each impacted member on all PCP terminations regardless of the number of members impacted.

34.2 Implement a process to monitor provider election submissions, delivery of network applications, credentialing process and outcomes by geographic area.

35. PHARMACY BENEFIT GENERAL REQUIREMENTS

35.1. The Agency may elect to carve out pharmacy benefit services from the integrated contract.

35.2 The Contractor shall:

35.2.1 Provide an integrated retail and mail-order prescription drug benefits program for active employees, COBRA participants, retirees, and their eligible dependents enrolled in the Agency of Arizona Saguaro Benefit plan;

35.2.2 Provide a retail pharmacy network with convenient access for members, including strong representation for rural and out-of-state employees.

35.2.3 Provide customer service featuring a dedicated toll-free line, 24/7/365 services, and responsive representatives with a solid working knowledge of the Agency's plan design, drug coverage, and formulary. Lines shall be equipped with appropriate technology to accept calls from all members. The Contractor is responsible for ensuring that people with limited English proficiency and those who are deaf or hearing impaired have access to communication services that enable all members to utilize the phone lines.

35.2.4 Provide a dedicated and responsive account management team, including clinical pharmacist support, focused on proactive and efficient management of prescription drug program service, operations, and cost trend.

35.2.5 Reduce and control the cost of prescription drugs within the perimeters of the program, in a clinically appropriate manner.

35.2.6 Provide a preferred drug list that result in lower cost per prescription, improved health outcomes, and lower total healthcare costs.

35.2.7 Offer utilization and health management programs (e.g., DUR, utilization edits, disease state management) that decrease inappropriate prescribing and medical utilization while promoting better compliance with best practice treatment guidelines and improved healthcare outcomes.

35.2.8 Provide drug utilization review programs that are integrated across the retail and mail order delivery channels.

35.2.9 Provide coordinated coverage with the Agency's contracted contractors for disease management and other services. The Contractor shall be capable and willing to work with other contractors to share prescription claims data on a frequent, scheduled basis, and in accordance with HIPAA privacy regulations.

35.2.10 Provide customer communications materials at no additional cost for use during transition and implementation periods, as well as for future program changes.

35.2.11 Provide standard key pharmacy reports (top drugs, top therapy classes, plan performance, DUR/clinical program results), as well as online or web-enabled reporting tool access.

35.2.12 Introduce innovative services that improve physician prescribing and treatment.

36. PHARMACY PROGRAM REQUIREMENTS

The contractor shall:

36.1 Meet the Plan Design requirements as stated in the Data Library. These changes shall be operational as of the implementation date and there can be no associated costs billed to THE AGENCY with the design and implementation of these programs.

36.2 Provide a network of preferred community pharmacies in areas which State employees reside. Pharmacies shall be within 1 mile in urban areas, 3 miles in suburban areas and 10 miles in rural areas.

36.3 Transmit prescription drug utilization and pricing (if applicable) data, fields determined by the Agency, to outside organizations as directed by the Agency (e.g., disease management contractor), at no additional cost. The Contractor shall not set a limit on the number of data requests.

36.4 Provide a mandatory comprehensive Maximum Allowable Cost (MAC) program for generic drugs that encourages generic substitution by patient, provider, and pharmacy. The Contractor shall guarantee the over all discount off of the AWP that the Agency will receive on all generic medications in addition to the effective MAC discount.

36.5 Provide a contracted fixed administrative fee per prescription.

36.7 Provide customized participant communications at no additional cost to the Agency. Contractor's customer service activities shall include, but are not limited to:

36.7.1 Separate 800 numbers for participants, providers, and pharmacists.

36.7.2 Access to a pharmacist 24/7/365.

36.7.3 Inquiry/service representatives assigned to the Agency account, for both the retail and mail order programs (these should be integrated).

36.7.4 Customer service representatives who speak Spanish fluently.

36.8 The Contractor shall perform all initial credentialing, monitoring, and re-credentialing of network pharmacies.

36.9 Perform periodic on-site audits of participating pharmacies as necessary (a minimum of 2 percent of network pharmacies in Arizona will be required).

36.10 Maintain records for auditing, management information, reporting and analysis.

36.11 Provide an assigned account representative, service representatives, responsive to inquiries, requests and issues raised by the Agency:

36.11.1 The primary account representatives, pharmacists and client manager shall be based in either the Mountain or Pacific time zones;

36.11.2 An assigned pharmacist to provide a reasonable amount of analytical assistance and clinical advice to the Agency;

36.11.3 An additional assigned pharmacist to perform provider counter-detailing within the Agency of Arizona solely for beneficiaries covered by the Agency.

36.12 Provide a clinically sound formulary administered on a strictly voluntary basis for the member. Contractors shall propose guaranteed minimum rebates, associated with utilization of formulary drugs, on a per paid claim basis. The Contractor shall have the requisite ability to customize the formulary recommended by the Contractor without significant decrease in the negotiated pharmaceutical rebates.

36.13 Agree that the pharmacy program shall be on administrative services only (ASO) for the duration of this contract.

37. PHARMACY PROGRAM PERFORMANCE STANDARDS

The contractor shall:

37.1 The Contractor shall to meet the Performance Standards outlined in the Performance Guarantees Section. The contractor shall ensure quality of service and responsiveness standards as outlined in both Attachment B and below:

38. PHARMACY SYSTEM AND REPORTING REQUIREMENTS

38.1 The Contractor shall submit monthly, quarterly, and annual reports as outlined in the Reporting Section. In addition to any reports not mentioned in the Reporting Section, the Agency expects the Contractor to provide the Agency with its standard utilization reporting package.

39. PERFORMANCE GUARANTEES- GENERAL TERMS

Performance Guarantee or Commitment	General Provisions or Definitions
General Terms	
Performance measurement period	Most measurements will be based on quarterly average results. From monthly reported results, quarterly results are derived using cumulative monthly raw data.

Performance Guarantee or Commitment	General Provisions or Definitions
Reporting frequency	Quarterly reporting of month-by-month, quarter-by-quarter, and annual average results provided throughout the year.
Separate guarantees and results reporting by plan	Performance results and guarantees will be measured separately by plan
One time Implementation Guarantee – Fees at Risk	5% of annual ASO fees.
Ongoing guarantees -- Overall Amount at Risk	25% of ASO fees. Allocation of amounts at risk are to be at the State of Arizona's discretion.
Client-specific or office-wide measurement and reporting	Results should be measured and reported on a client-specific basis.
Penalty application	Penalty application will be applied on a pass/fail basis. Thus, if the vendor's performance falls below performance standard, then full penalty applies.
Evaluation & payment of penalties	Evaluation of performance guarantee results will be performed following the end of each policy year. Amounts at risk for quarterly penalties will be one-forth of annual ASO fees paid.
Claims quality standards – independent verification	The State may choose to have an audit performed by a claims auditor designated by the State Agency using the frequency, volume and sample selection as designated by the State Agency. Frequency of audit is to be determined by the State Agency. Vendor is to have input into the audit findings prior to the final report. Performance guarantee penalty risk is based on the final report findings.
Changes	Any changes in performance guarantee standards or terms require advance notification and mutual agreement by the parties.

40. Performance Guarantee Standards

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
Implementation			
ID Card Issuance (client-specific; implementation)	99% issued within 10 business days of receipt of data/information received from ADOA	1% of annual administration fee	Supplier report, random audit, or member survey; completion of task by cut0off date; reported and measured annually
ID Card Accuracy (client-specific; implementation)	98% correct; Less than 2% of employees calling with problems requiring re-issue	1% of annual administration fee	Supplier report, random audit, or member survey; reported and measured annually
Implementation activities to include system testing, procedure identification, coordination w/ other vendors (client-specific; implementation)	Program implementation and "go live" by October 1, 2004 with no delays or impact to State employees or retirees. Performance will be measured by ADOA following completion of all implementation activities to the ADOA's satisfaction for a plan start date of October 1, 2004.	1% of annual administration fee	Completion of all implementation activities to the ADOA's satisfaction for a plan start date of October 1, 2004 or date identified by Agency.
Claims Quality			
Claims Processing Accuracy: 99.0% (client-specific; quarterly)	The percentage of audited claims processed accurately. Calculated as the total number of audited claims minus the number of claims processed with error, divided by the total number of audited claims. Error definition includes any type of error (coding, procedural, system, payment, etc.), whether a payment or non-payment error. Each type of error is counted as	3% of annual administration fee	Supplier reports, random audit, or member survey; reported quarterly and measured annually

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
	one full error and no more than one error can be assigned to one claim.		
Financial Payment (Dollar) Accuracy : 99.0% (client-specific; quarterly)	The percentage of audited claim dollars paid accurately. Calculated as the total audited "paid" dollars minus the absolute value of over- and underpayments, divided by total audited paid dollars.	3% of annual administration fee	Supplier report, random audit, or member survey; reported quarterly and measured annually
Payment Incidence Accuracy: 97.0% (client-specific; quarterly)	The percentage of audited claims processed without payment error. Calculated as the total number of audited claims (pays and no pays) minus the number of claims processed with payment error, divided by the total number of audited claims. Error is defined as any error, regardless of cause (e.g., coding, procedural, system) that results in an overpayment or an underpayment. Each type of error is counted as one full error and no more than one error can be assigned to one claim.	3% of annual administrative fee	Supplier report, random audit, or member survey; reported quarterly and measured annually
Claims turnaround time	90% processed within 10 business days 98% processed within 15 business days 99% processed within 22 business days 98% of investigated claims processed within 30 days with payment to providers,	3% of annual administration fee	Supplier reports, random audit, or member survey; reported quarterly and measured annually

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
	members within the next 7 days		
Customer Service			
Telephone Response Time:	90% of calls answered in 30 seconds or less	1% of annual administration fee	Supplier telephone reports, random audit, or member survey; reported quarterly and measured annually
Time on Hold	Average time on hold of 20 seconds or less	1% of annual administration fee	Supplier telephone reports, random audit, or member survey; reported quarterly and measured annually
Call Abandonment Rate:	Less than 3% of all calls abandoned	1% of annual administration fee	Supplier telephone reports, random audit, or member survey; reported quarterly and measured annually
Correspondence	92% of written inquiries resolved within 30 days 95% resolved within 60 days 99% resolved within 120 days	1% of annual administration fee	Supplier reports, random audit, or member survey; reported quarterly and measured annually
Account Management: (client-specific; quarterly)	Score card to be developed with input from State of Arizona based on service criteria of key importance. Average score of 4 or better Will include such things as: evaluation of account management team (e.g., accessibility, responsiveness, interpersonal relationship skills, communication skills, technical	1% of annual administration fee	Supplier telephone reports, random audit, or member survey; reported quarterly and measured annually

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
	knowledge and skills, client service meetings, etc.), timeliness of reporting (standard and ad hoc reports), timely resolution of issues.		
Reporting			
Report timeliness (client-specific; monthly, quarterly, semi-annually, and annually)	Vendor will provide monthly, quarterly, and annual experience reports to the State of Arizona as outlined in the reporting section; as well as ad hoc reports as needed and within mutually agreed upon timeframes. Standards: ▪ Monthly reports within 20 days ▪ Quarterly reports: received by the State within 40 days after close of the month or quarter. ▪ Annual summary reports received by the State within 60 days after close of the year. ▪ Ad hoc reports within 10 days	$1,000 per day for each day reports untimely. For each successive period for which the standard is not met, the penalties will increase an additional $100 per day.	Supplier reports, random audit, or member survey; reported quarterly and measured annually
Administration			
Eligibility Data	100% of eligibility files processed within 5 business days	1% of annual administration fee	Measurement following each tape receipt; reported monthly and measured

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
			quarterly
Satisfaction			
Member Satisfaction with Administrator Services	85% of members rank services as good, very good, or excellent	3% of annual administration fee	Member satisfaction survey performed by the State; reported and measured annually
Employee Material Requests			
	Deliver requested materials at least 14 days prior to Open Enrollment; during open enrollment to potential enrollees within 7 working days of request; and membership materials to new employees or those with changes within 7 working days of request	1% of annual administration fee	Valid complaints from employees who report problems to the State
Program Management/ Network			
PCP Turnover	PCP turnover rate of 5% or less	1% of annual administration fee	Supplier report, random audit or member survey; reported and measured annually
Member Satisfaction with Network	85% of members rank network as good, very good, or excellent	3% of annual administration fee	Member satisfaction survey performed by the State; reported

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
			and measured annually
Satisfaction with time to obtain routine appointment	82% of members rank network regarding time to obtain routine appointment as good, very good, or excellent	1% of annual administration fee	Member satisfaction survey performed by the State; reported and measured annually
Referral Turnaround Time	82% of members surveyed rank network regarding the process to obtain a referral to a specialist as good, very good, or excellent	1% of annual administration fee	Member satisfaction survey performed by the State; reported and measured annually
Appointment Wait Time	82% of members surveyed rank appointment wait time as good, very good, or excellent	1% of annual administration fee	Member satisfaction survey performed by the State; reported and measured annually
Employee Material Requests	Deliver requested materials during open enrollment to potential enrollees within 7 working days of request	1% of annual administration fee	Valid complaints from employees who report problems to the State
<u>Care Management</u>			
Physical Exams	90% within 7 calendar days for Problem Specific; 90% within 30 calendar days for Non-Urgent (e.g., Wellness or Preventive)	1% of annual administration fee	Supplier report, random audit by the State, complaints received and recorded; reported quarterly and measured annually

Performance Guarantee Standards	Requested Standard	Amount at Risk	Measurement
Specialty Appointments	95% within 24 hours for Problem Specific; 85% within 14 calendar days for Non-Urgent (e.g., Wellness or Preventive)	1% of annual administration fee	Supplier report, random audit by the State, complaints received and recorded; reported quarterly and measured annually
Urgent Exam	95% within 24 hours	1% of annual administration fee	Supplier report, random audit by the State, complaints received and recorded; reported quarterly and measured annually
Emergency Exam	99% within 4 hours	1% of annual administration fee	Supplier report, random audit by the State, complaints received and recorded; reported quarterly and measured annually

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

Rx_Information.xls

The Excel Spreadsheet is embedded in the Icon
Click the Icon to open the File

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

PPO Network Information.xls

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State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

EPO Network Information.xls

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State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

Financial_Information.xls

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1. Definition of Terms. As used in this Solicitation and any resulting Contract, the terms listed below are defined as follows:

1.1 "*Attachment*" means any item the Solicitation requires the Offeror to submit as part of the Offer.

1.2 "*Contract*" means the combination of the Solicitation, including the Uniform and Special Instructions to Offerors, the Uniform and Special Terms and Conditions, and the Specifications and Statement or Scope of Work; the Offer and any Best and Final Offers; and any Solicitation Amendments or Contract Amendments.

1.3 "*Contract Amendment*" means a written document signed by the Procurement Officer that is issued for the purpose of making changes in the Contract.

1.4 "*Contractor*" means any person who has a Contract with the State.

1.5 "*Days*" means calendar days unless otherwise specified.

1.6 "*Exhibit*" means any item labeled as an Exhibit in the Solicitation or placed in the Exhibits section of the Solicitation.

1.7 "*Gratuity*" means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.

1.8 "*Materials*" means all property, including equipment, supplies, printing, insurance and leases of property but does not include land, a permanent interest in land or real property or leasing space.

1.9 "*Procurement Officer*" means the person, or his or her designee, duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract.

1.10 "*Services*" means the furnishing of labor, time or effort by a contractor or subcontractor which does not involve the delivery of a specific end product other than required reports and performance, but does not include employment agreements or collective bargaining agreements.

1.11 "*Subcontract*" means any Contract, express or implied, between the Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract.

1.12 "*State*" means the State of Arizona and Department or Agency of the State that executes the Contract.

1.13 "*State Fiscal Year*" means the period beginning with July 1 and ending June 30.

2 Contract Interpretation

2.1 Arizona Law. The Arizona law applies to this Contract including, where applicable, the Uniform Commercial Code as adopted by the State of Arizona and the Arizona Procurement Code, Arizona Revised Statutes (A.R.S.) Title 41, Chapter 23, and its implementing rules, Arizona Administrative Code (A.A.C.) Title 2, Chapter 7.

2.2. Implied Contract Terms. Each provision of law and any terms required by law to be in this Contract are a part of this Contract as if fully stated in it.

2.3. Contract Order of Precedence. In the event of a conflict in the provisions of the Contract, as accepted by the State and as they may be amended, the following shall prevail in the order set forth below:

2.3.1 Special Terms and Conditions;
2.3.2 Uniform Terms and Conditions;
2.3.3 Statement or Scope of Work;
2.3.4 Specifications;
2.3.5 Attachments;
2.3.6 Exhibits;
2.3.7 Documents referenced or included in the Solicitation.

2.4 Relationship of Parties. The Contractor under this Contract is an independent Contractor. Neither party to this Contract shall be deemed to be the employee or agent of the other party to the Contract.

2.5 Severability. The provisions of this Contract are severable. Any term or condition deemed illegal or invalid shall not affect any other term or condition of the Contract.

2.6 No Parole Evidence. This Contract is intended by the parties as a final and complete expression of their agreement. No course of prior dealings between the parties and no usage of the trade shall supplement or explain any terms used in this document and no other understanding either oral or in writing shall be binding.

2.7 No Waiver. Either party's failure to insist on strict performance of any term or condition of the Contract shall not be deemed a waiver of that term or condition even if the party accepting or acquiescing in the nonconforming performance knows of the nature of the performance and fails to object to it.

3. Contract administration and operation.

3.1 Records. Under A.R.S. § 35-214 and § 35-215, the Contractor shall retain and shall contractually require each subcontractor to retain all data and other "records" relating to the acquisition and performance of the Contract for a period of five years after the completion of the Contract. All records shall be subject to inspection and audit by the State at reasonable times. Upon request, the Contractor shall produce a legible copy of any or all such records.

3.2 Non-Discrimination. The Contractor shall comply with State Executive Order No. 99-4 and all other applicable Federal and State laws, rules and regulations, including the Americans with Disabilities Act.

3.3 Audit. Pursuant to ARS § 35-214, at any time during the term of this Contract and five (5) years thereafter, the Contractor's or any subcontractor's books and records shall be subject to audit by the State and, where applicable, the Federal Government, to the extent that the books and records relate to the performance of the Contract or Subcontract.

3.4 Facilities Inspection and Materials Testing. The Contractor agrees to permit access to its facilities, subcontractor facilities and the Contractor's processes or services, at reasonable times for inspection of the facilities or materials covered under this Contract. The State shall also have the right to test, at its own cost, the materials to be supplied under this Contract. Neither inspection of the Contractor's facilities nor materials testing shall constitute final acceptance of the materials or services. If the State determines non-compliance of the materials, the Contractor shall be responsible for the payment of all costs incurred by the State for testing and inspection.

3.5 Notices. Notices to the Contractor required by this Contract shall be made by the State to the person indicated on the Offer and Acceptance form submitted by the Contractor unless otherwise stated in the Contract. Notices to the State required by the Contract shall be made by the Contractor to the Solicitation Contact Person indicated on the Solicitation cover sheet, unless otherwise stated in the Contract. An authorized Procurement Officer and an authorized Contractor representative may change their respective person to whom notice shall be given by written notice to the other and an amendment to the Contract shall not be necessary.

3.6 Advertising, Publishing and Promotion of Contract. The Contractor shall not use, advertise or promote information for commercial benefit concerning this Contract without the prior written approval of the Procurement Officer.

3.7 Property of the State. Any materials, including reports, computer programs and other deliverables, created under this Contract are the sole property of the State. The Contractor is not entitled to a patent or copyright on those materials and may not transfer the p tent or copyright to anyone else. The Contractor shall not use or release these materials without the prior written consent of the State.

3.8 Ownership of Intellectual Property. Any and all intellectual property, including but not limited to copyright, invention, trademark, trade name, service mark, and/or trade secrets created or conceived pursuant to or as a result of this contract and any related subcontract ("Intellectual Property"), shall be work made for hire and the State shall be considered the creator of such Intellectual Property. The agency, department, division, board or commission of the State of Arizona requesting the issuance of the contract shall own (for and on behalf of the State) the entire right, title and interest to the Intellectual Property throughout the world. Contractor shall notify the State, within thirty (30) days, of the creation of any Intellectual Property by it or its subcontractor(s). Contractor, on behalf of itself and any subcontractor (s), agrees to execute any and all document(s) necessary to assure ownership of the Intellectual Property vests in the State and shall take no affirmative actions that might have the effect of vesting all or part of the Intellectual Property in any entity other than the State. The Intellectual Property shall not be disclosed by contractor or its subcontractor(s) to any entity not the State without the express written authorization of the agency, department, division, board or commission of the State of Arizona requesting the issuance of this contract.

4 Costs and Payments

4.1 Payments. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of goods or services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days.

4.2 Delivery. Unless stated otherwise in the Contract, all prices shall be F.O.B. Destination and shall include all freight delivery and unloading at the destination.

4.3 Applicable Taxes.

4.3.1 Payment of Taxes. The Contractor shall be responsible for paying all applicable taxes.

4.3.2 State and Local Transaction Privilege Taxes. The State of Arizona is subject to all applicable state and local transaction privilege taxes. Transaction privilege taxes apply to the sale and are the responsibility of the seller to remit. Failure collect such taxes from the buyer does not relieve the seller from its obligation to remit taxes.

4.3.3 Tax Indemnification. Contractor and all subcontractors shall pay all Federal, state and local taxes applicable to its operation and any persons employed by the Contractor. Contractor shall, and require all subcontractors to hold the State harmless from any responsibility for taxes, damages and interest, if applicable, contributions required under Federal, and/or state and local laws and regulations and any other costs including transaction privilege taxes, unemployment compensation insurance, Social Security and Worker's Compensation.

4.3.4 IRS W9 Form. In order to receive payment the Contractor shall have a current IRS W9 Form on file with the State of Arizona, unless not required by law.

4.4 Availability of Funds for the Next State fiscal year. Funds may not presently be available for performance under this Contract beyond the current state fiscal year. No legal liability on the part of the State for any payment may arise under this Contract beyond the current state fiscal year until funds are made available for performance of this Contract.

4.5 Availability of Funds for the current State fiscal year. Should the State Legislature enter back into session and reduce the appropriations or for any reason and these goods or services are not funded, the State may take any of the following actions:

4.5.1 Accept a decrease in price offered by the, contractor
4.5.2 Cancel the Contract
4.5.3 Cancel the contract and re-solicit the requirements.

5 Contract changes

5.1 Amendments. This Contract is issued under the authority of the Procurement Officer who signed this Contract. The Contract may be modified only through a Contract Amendment within the scope of the Contract. Changes to the Contract, including the addition of work or materials, the revision of payment terms, or the substitution of work or materials, directed by a person who is not specifically authorized by the procurement officer in writing or made unilaterally by the Contractor are violations of the Contract and of applicable law. Such changes, including unauthorized written Contract Amendments shall be void and without effect, and the Contractor shall not be entitled to any claim under this Contract based on those changes.

5.2 Subcontracts. The Contractor shall not enter into any Subcontract under this Contract for the performance of this contract without the advance written approval of the Procurement Officer. The Contractor shall clearly list any proposed subcontractors and the subcontractor's proposed responsibilities. The Subcontract shall incorporate by reference the terms and conditions of this Contract.

5.3 Assignment and Delegation. The Contractor shall not assign any right nor delegate any duty under this Contract without the prior written approval of the Procurement Officer. The State shall not unreasonably withhold approval.

6 Risk and Liability

6.1 Risk of Loss. The Contractor shall bear all loss of conforming material covered under this Contract until received by authorized personnel at the location designated in the purchase order or Contract. Mere receipt does not constitute final acceptance. The risk of loss for nonconforming materials shall remain with the Contractor regardless of receipt.

6.2 Indemnification

6.2.1 Contractor/Vendor Indemnification (Not Public Agency) The parties to this contract agree that the State of Arizona, its' departments, agencies, boards and commissions shall be indemnified and held harmless by the contractor for the vicarious liability of the State as a result of entering into this contract. However, the parties further agree that the State of Arizona, its' departments, agencies, boards and commissions shall be responsible for its' own negligence. Each party to this contract is responsible for its' own negligence.

6.2.2 Public Agency Language Only Each party (as 'indemnitor') agrees to indemnify, defend, and hold harmless the other party (as 'indemnity") from and against any and all claims, losses, liability, costs, or expenses (including reasonable attorney's fees) (hereinafter collectively referred to as 'claims') arising out of bodily injury of any person (including death) or property damage but only to the extent that such claims which result in vicarious/derivative liability to the indemnity, are caused by the act, omission, negligence, misconduct, or other fault of the indemnity, its' officers, officials, agents, employees, or volunteers."

6.3. Indemnification - Patent and Copyright. The Contractor shall indemnify and hold harmless the State against any liability, including costs and expenses, for infringement of any patent, trademark or copyright arising out of Contract performance or use by the State of materials furnished or work performed under this Contract. The State shall reasonably notify the Contractor of any claim for which it may be liable under this paragraph. If the contractor is insured pursuant to A.R.S. § 41-621 and § 35-154, this section shall not apply.

6.4. Force Majeure.

6.4.1 Except for payment of sums due, neither party shall be liable to the other nor deemed in default under this Contract if and to the extent that such party's performance of this Contract is prevented by reason of force majeure. The term "force majeure" means an occurrence that is beyond the control of the party affected and occurs without its fault or negligence. Without limiting the foregoing, force majeure includes acts of God; acts of the public enemy; war; riots; strikes; mobilization; labor disputes; civil disorders; fire; flood; lockouts; injunctions-intervention-acts; or failures or refusals to act by government authority; and other similar occurrences beyond the control of the party declaring force majeure which

such party is unable to prevent by exercising reasonable diligence.

6.4.2 Force Majeure shall not include the following occurrences:

6.4.2.1 Late delivery of equipment or materials caused by congestion at a manufacturer's plant or elsewhere, or an oversold condition of the market;

6.4.2.2 Late performance by a subcontractor unless the delay arises out of a force majeure occurrence in accordance with this force majeure term and condition; or

6.4.2.3 Inability of either the Contractor or any subcontractor to acquire or maintain any required insurance, bonds, licenses or permits.

6.4.3 If either party is delayed at any time in the progress of the work by force majeure, the delayed party shall notify the other party in writing of such delay, as soon as is practicable and no later than the following working day, of the commencement thereof and shall specify the causes of such delay in such notice. Such notice shall be delivered or mailed certified-return receipt and shall make a specific reference to this article, thereby invoking its provisions. The delayed party shall cause such delay to cease as soon as practicable and shall notify the other party in writing when it has done so. The time of completion shall be extended by Contract Amendment for a period of time equal to the time that results or effects of such delay prevent the delayed party from performing in accordance with this Contract.

6.4.4 Any delay or failure in performance by either party hereto shall not constitute default hereunder or give rise to any claim for damages or loss of anticipated profits if, and to the extent that such delay or failure is caused by force majeure

.

6.5 Third Party Antitrust Violations. The Contractor assigns to the State any claim for overcharges resulting from antitrust violations to the extent that those violations concern materials or services supplied by third parties to the Contractor, toward fulfillment of this Contract.

7. Warranties

7.1 Liens. The Contractor warrants that the materials supplied under this Contract are free of liens and shall remain free of liens.

7.2 Quality. Unless otherwise modified elsewhere in these terms and conditions, the Contractor warrants that, for one year after acceptance by the State of the materials, they shall be:

7.2.1 Of a quality to pass without objection in the trade under the Contract description;

7.2.2 Fit for the intended purposes for which the materials are used;

7.2.3 Within the variations permitted by the Contract and are of even kind, quantity, and quality within each unit and among all units;

7.2.4 Adequately contained, packaged and marked as the Contract may require; and

7.2.5 Conform to the written promises or affirmations of fact made by the Contractor.

7.3 Fitness. The Contractor warrants that any material supplied to the State shall fully conform to all requirements of the Contract and all representations of the Contractor, and shall be fit for all purposes and uses required by the Contract.

7.4 Inspection/Testing. The warranties set forth in subparagraphs 7.1 through 7.3 of this paragraph are not affected by inspection or testing of or payment for the materials by the State.

7.5. Year 2000.

7.5.1 Notwithstanding any other warranty or disclaimer of warranty in this Contract, the Contractor warrants that all products delivered and all services rendered under this Contract shall comply in all respects to performance and delivery requirements of the specifications and shall not be adversely affected by any date-related data Year 2000 issues. This warranty shall survive the expiration or termination of this Contract. In addition, the defense of force majeure shall not apply to the Contractor's failure to perform specification requirements as a result of any date-related data Year 2000 issues.

7.5.2 Additionally, notwithstanding any other warranty or disclaimer of warranty in this Contract, the Contractor warrants that each hardware, software, and firmware product delivered under this Contract shall be able to accurately process date/time data (including but not limited to calculation, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000 and leap year calculations, to the extent that other information technology utilized by the State in combination with the information technology being acquired under this Contract properly exchanges date-time data with it. If this Contract requires that the information technology products being acquired perform as a system, or that the information technology products being acquired perform as a system in combination with other State information technology, then this warranty shall apply to the acquired products as a system. The remedies available to the State for breach of this warranty shall include, but shall not be limited to, repair and replacement of the information technology products delivered under this Contract. In addition, the defense of force majeure shall not apply to the failure of the Contractor to perform any specification requirements as a result of any date-related data Year 2000 issues.

7.6. Compliance With Applicable Laws. The materials and services supplied under this Contract shall comply with all applicable Federal, state and local laws, and the Contractor shall maintain all applicable licenses and permit requirements.

7.7. Survival of Rights and Obligations after Contract Expiration or Termination.

7.7.1 Contractor's Representations and Warranties. All representations and warranties made by the Contractor under this Contract shall survive the expiration or termination hereof. In addition, the parties hereto acknowledge that pursuant to A.R.S. § 12-510, except as provided in A.R.S. § 12-529, the State is not subject to or barred by any limitations of actions prescribed in A.R.S., Title 12, Chapter 5.

7.7.2 Purchase Orders. The Contractor shall, in accordance with all terms and conditions of the Contract, fully perform and shall be obligated to comply with all purchase orders received by the Contractor prior to the expiration or termination hereof, unless otherwise directed in writing by the Procurement Officer, including, without limitation, all purchase orders received prior to but not fully performed and satisfied at the expiration or termination of this Contract.

8 State's Contractual Remedies

8.1 Right to Assurance. If the State in good faith has reason to believe that the Contractor does not intend to, or is unable to perform or continue performing under this Contract, the Procurement Officer may demand in writing that the Contractor give a written assurance of intent to perform. Failure by the Contractor to provide written assurance within the number of Days specified in the demand may, at the State's option, be the basis for terminating the Contract under the Uniform Terms and Conditions or other rights and remedies available by law or provided by the contract.

8.2 Stop Work Order.

8.2.1 The State may, at any time, by written order to the Contractor, require the Contractor to stop all or any part, of the work called for by this Contract for period(s) of days indicated by the State after the order is delivered to the Contractor. The order shall be specifically identified as a stop work order issued under this clause. Upon receipt of the order, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize the incurrence of costs allocable to the work covered by the order during the period of work stoppage.

8.2.2 If a stop work order issued under this clause is canceled or the period of the order or any extension expires, the Contractor shall resume work. The Procurement Officer shall make an equitable adjustment in the delivery schedule or Contract price, or both, and the Contract shall be amended in writing accordingly.

8.3 Non-exclusive Remedies. The rights and the remedies of the State under this Contract are not exclusive.

8.4 Nonconforming Tender. Materials or services supplied under this Contract shall fully comply with the Contract. The delivery of materials or services or a portion of the materials or services that do not fully comply constitutes a breach of contract. On delivery of nonconforming materials or services, the State may terminate the Contract for default under applicable termination clauses in the Contract, exercise any of its rights and remedies under the Uniform Commercial Code, or pursue any other right or remedy available to it.

8.5 Right of Offset. The State shall be entitled to offset against any sums due the Contractor, any expenses or costs incurred by the State, or damages assessed by the State concerning the Contractor's non-conforming performance or failure to perform the Contract, including expenses, costs and damages described in the Uniform Terms and Conditions.

9 Contract Termination

9.1 Cancellation for Conflict of Interest. Pursuant to A.R.S. § 38-511, the State may cancel this Contract within three (3) years after Contract execution without penalty or further obligation if any person significantly involved in initiating, negotiating, securing, drafting or creating the Contract on behalf of the State is or becomes at any time while the Contract or an extension of the Contract is in effect an employee of or a consultant to any other party to this Contract with respect to the subject matter of the Contract. The cancellation shall be effective when the Contractor receives written notice of the cancellation unless the notice specifies a later time. If the Contractor is a political subdivision of the State, it may also cancel this Contract as provided in A.R.S. § 38-511.

9.2 Gratuities. The State may, by written notice, terminate this Contract, in whole or in part, if the State determines that employment or a Gratuity was offered or made by the Contractor or a representative of the Contractor to any officer or employee of the State for the purpose of influencing the outcome of the procurement or securing the Contract, an amendment to the Contract, or favorable treatment concerning the Contract, including the making of any determination or decision about contract performance. The State, in addition to any other rights or remedies, shall be entitled to recover exemplary damages in the amount of three times the value of the Gratuity offered by the Contractor.

9.3 Suspension or Debarment. The State may, by written notice to the Contractor, immediately terminate this Contract if the State determines that the Contractor has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity, including but not limited to, being disapproved as a subcontractor of any public procurement unit or other governmental body. Submittal of an offer or execution of a contract shall attest that the contractor is not currently suspended or debarred. If the contractor becomes suspended or debarred, the contractor shall immediately notify the State.

9.4 Termination for Convenience. The State reserves the right to terminate the Contract, in whole or in part at any time, when in the best interests of the State without penalty or recourse. Upon receipt of the written notice, the Contractor shall stop all work, as directed in the notice, notify all subcontractors of the effective date of the termination and minimize all further costs to the State. In the event of termination under this paragraph, all documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State upon demand. The Contractor shall be entitled to receive just and equitable compensation for work in progress, work completed and materials accepted before the effective date of the termination. The cost principles and procedures provided in A.A.C. R2-7-701 shall apply.

9.5 Termination for Default.

9.5.1 In addition to the rights reserved in the contract, the State may terminate the Contract in whole or in part due to the failure of the Contractor to comply with any term or condition of the Contract, to acquire and maintain all required insurance policies, bonds, licenses and permits, or to make satisfactory progress in performing the Contract. The Procurement Officer shall provide written notice of the termination and the reasons for it to the Contractor.

9.5.2 Upon termination under this paragraph, all goods, materials, documents, data and reports prepared by the Contractor under the Contract shall become the property of and be delivered to the State on demand.

9.5.3 The State may, upon termination of this Contract, procure, on terms and in the manner that it deems appropriate, materials or services to replace those under this Contract. The Contractor shall be liable to the State for any excess costs incurred by the State in procuring materials or services in substitution for those due from the Contractor.

9.6 Continuation of Performance Through Termination. The Contractor shall continue to perform, in accordance with the requirements of the Contract, up to the date of termination, as directed in the termination notice.

10. Contract Claims. All contract claims or controversies under this Contract shall be resolved according to A.R.S. Title 41, Chapter 23, Article 9, and rules adopted thereunder.

11. Arbitration. The parties to this Contract agree to resolve all disputes arising out of or relating to this contract through arbitration, after exhausting applicable administrative review, to the extent required by A.R.S. § 12-1518, except as may be required by other applicable statutes (Title41).

12. Comments Welcome. The State Procurement Office periodically reviews the Uniform Terms and Conditions and welcomes any comments you may have. Please submit your comments to: State Procurement Administrator, State Procurement Office, 100 North 15th Avenue, Suite 104, Phoenix, Arizona, 85007.

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

YOU ARE ADVISED TO READ THE UNIFORM TERMS AND CONDITIONS OF THIS SOLICITATION. THESE SPECIAL TERMS AND CONDITIONS SUPPLEMENT THE UNIFORM TERMS AND CONDITIONS AND OPERATE AFTER THE AWARD OF THE CONTRACT.

1. Term of Contract: The term of the contract shall begin upon award and shall remain in effect for a period of one (1) year unless terminated, cancelled or extended as otherwise provided herein.

2. Option to Extend the Term of the Contract. An option is defined as a unilateral right in a contract that, for a specified time, the State may elect to extend the term of the contract. The State may extend the term of this contract by written amendment to the Contractor on or before the date of contract expiration. If the State exercises this option, the extended contract shall be considered to include this option clause. The State shall exercise this option for four (4) one year periods or any portion of a year thereof. The total duration of this contract, including the exercise of any options under this clause, shall not exceed five (5) years.

3. RESERVED

4. Availability of Funds for the Next Fiscal Year: Funds are not presently available for performance under this contract beyond the current fiscal year. The State's obligation for performance of this contract beyond this fiscal year is contingent upon the availability of funds from which payment for contract purposes can be made. No legal liability on the part of the State for any payment may arise for performance under this contract beyond the current fiscal year until funds are made available for performance of this contract.

5. Confidentiality of Records: The Contractor shall establish and maintain procedures and controls that are acceptable to the State for the purpose of assuring that no information contained in its records or obtained from the State or from others in carrying out its functions under the contract shall be used by or disclosed by it, its agents, officers, or employees, except as required to efficiently perform duties under the contract. Persons requesting such information shall be referred to the State. Contractor also agrees that any information pertaining to individual persons shall not be divulged other than to employees or officers of the Contractor as needed for the performance of duties under the contract, unless otherwise agreed to in writing by the State.

6. Confidentiality of Information: The contractor shall treat all information, and in particular, information relating to recipients and providers, which is obtained by it through its performance under the contract, as confidential information to the extent that confidential treatment is provided under State and federal law, and shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and protection of its rights hereunder.

7. Records: The contractor shall maintain books, records, documents and other evidence pertaining to the costs and expenses of the contract, hereinafter collectively called the "records," to the extent and in such detail as will properly reflect all net costs, direct or indirect, of labor, materials, equipment, supplies and services, and other costs and expenses of whatever nature for which payment is made under the contract. The contractor shall agree to make available at the office of the contractor at all

reasonable times during the period, as set forth below, any of the records for inspection, audit or reproduction by any authorized representative of the State of Arizona. The contractor shall preserve and make available the records for a period of five years from the date of final payment under the contract and for such period, if any, as is required by applicable stature, by any other paragraph of the contract as stated below:

7.1 If the contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of five years from the date of any resulting final settlement.

7.2 Records which relate to appeals, litigations or the settlement of claims arising out of the performance of the contract, or cost and expenses of the contract as to which exception has been taken by the State Agency, shall be retained by the contractor until such appeals, litigations, claims or exceptions have been resolved. The provisions of this section shall be applicable to and included in each subcontract hereunder.

8. Key Personnel: It is essential that the Contractor provide an adequate staff of experienced personnel, capable of and devoted to the successful accomplishment of work to be performed under this contract. The Contractor must assign specific individuals to the key positions. Once assigned to work under the contract, key personnel shall not be removed or replaced without the prior written approval of the using Agency.

9. Contractor Personnel: During the course of the contract, the State reserves the right to require the contractor to reassign or otherwise remove from the project any contractor employees found unacceptable by the State.

9.1 The State also reserves the right to approve, in advance in writing, any changes to the contractor personnel specified in the contractor's proposal. The State will not unreasonably exercise the rights reserved under this paragraph.

10. Insurance.

A. Without limiting any liabilities or any other obligation of the contractor, the contractor shall purchase and maintain, in a company or companies lawfully authorized to do business in the State of Arizona, and rated at least "A VII" in the current A.M. Best's, the minimum insurance coverage below:

1. Commercial General Liability, with minimum limits of $1,000,000.00 per occurrence, and an unimpaired products and completed operations aggregate limit and general aggregate minimum limit of $2,000,000.00. Coverage shall be at least as broad as the Insurance Service Office, Inc. Form CG25031185, issued on an Occurrence basis, and endorsed to add the State of Arizona as an Additional Insured with reference to this contract. The policy shall include coverage for:

Bodily Injury;
Broad Form Property Damage (including completed operations);
Personal Injury;
Blanket Contractual Liability;
Products and Completed Operations, and this coverage shall extend for one (1) year past acceptance, cancellation or termination of the services or work defined in this contract;
Fire Legal Liability.

2. Business Automobile Liability, with minimum limits of $1,000,000.00 per occurrence combined single limit, with Insurance Service Office, Inc. Declarations to include Symbol One (Any Auto) applicable to claims arising from bodily injury, death or property damage arising out of the ownership, maintenance or use of any auto. The policy shall be endorsed to add the State of Arizona as an Additional Insured with reference to this contract.

3. Worker's Compensation (Coverage A): Statutory Arizona benefits;
Employer's Liability (Coverage B): $500,000.00 each accident
$500,000.00 each employee/disease;
$1,000,000.00 policy limit/disease.

Policy shall include endorsement for all State coverage for state of hire.

4. Professional Liability Insurance with minimum limits of $1,000.000.00 Each Claim (or Each Wrongful Act) with a Retroactive Liability Date (if applicable to Claims-Made coverage) the same as the effective date of this contract. The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Work or specifications of this contract and, at the discretion of the State of Arizona, shall include one of the following types of Professional Liability policies:

Directors and Officers;
Errors and Omissions;
Medical Malpractice;
Druggists Professional;
Architects/Engineers Professional;
Lawyers Professional;
Teachers Professional;
Accountants Professional;
Social Workers Professional.

The State of Arizona shall be named as an Additional Insured as its interests may appear.
The policy shall contain an Extended Claim Reporting Provision of not less than one (1) year following termination of the policy.

B. The State of Arizona reserves the right to request and receive certified copies of all policies and endorsements within ten (10) calendar days of contract signature.

C. Certificates of Insurance acceptable to the State of Arizona shall be issued and delivered prior to the commencement of the work defined in this contract, and shall identify this contract and include certified copies of endorsements naming the State of Arizona as Additional Insured for liability coverages. The certificates, insurance policies and endorsements required by this paragraph shall contain a provision that coverages afforded will not be canceled until at least 50 days prior written notice has been given to the State of Arizona. All coverages, conditions limits and endorsements shall remain in full force and effect as required in this contract.

D. Failure on the part of the Contractor to meet these requirements shall constitute a material breach of contract, upon which the State of Arizona my immediately terminate this agreement or, at its discretion, procure or renew such insurance and pay any and all premiums in connection therewith, and all monies so paid by the State of Arizona shall be repaid by the contractor upon demand, or the State of Arizona may offset the cost of the premiums against any monies due to the contractor. Costs for coverages broader than those required or for limits in excess of those required shall not be charged to the State of Arizona. Contractor and its insurer(s) providing the required coverages shall waive their rights of recovery against the State of Arizona, its Departments, Employees and Officers, Agencies, Boards and Commissions.

Within fifteen (15) days following notification of award, certificates of insurance must be submitted to the State Procurement Office, clearly stating the applicable contract number, effective date(s) of coverage, and limits of liability required pursuant to the contract.
Within fifteen (15) days following notification (contract amendment executing the option) of the exercise of an option to extend the contract period of performance certificates of insurance must be submitted to the State Procurement Office, clearly stating the applicable contract number, effective date(s) of coverage, and limits of liability required pursuant to the contract.

11. Eligible Agencies This contract shall be for STATEWIDE use.

12. Contract Defined

12.1 The contract between the State of Arizona and the contractor shall consist of (1) the Request for Proposal (RFP) and any amendments thereto, and (2) the proposal submitted by the contractor in response to the RFP. In the event of a conflict in language between the two documents referenced above, the provisions and requirements set forth and/or referenced in the Request for Proposal shall govern. However, the State reserves the right to clarify any contractual relationship in writing, and such written clarification shall govern in case of conflict with the applicable requirements stated in the RFP or the contractor's proposal. In all other matters not affected by the written clarification, if any, the Request for Proposal shall govern.

12.2 The contract shall be construed according to the laws of the State of Arizona. The State of Arizona is not obligated for expenditures under the contract until funds have been encumbered.

12.3 The contractor agrees and understands that the State of Arizona's agreement to the contract is predicated, in part and among other considerations, on the utilization of the specific individual(s) and/or personnel qualification(s) as identified and/or described in the contractor's proposal. Therefore, the contractor agrees that no substitution of such specified individuals and/or personnel qualifications shall be made without the prior written approval of the State Agency. The contractor further agrees that any substitution made pursuant to this paragraph must be equal or better than originally proposed and that the State Agency's approval of a substitution shall not be construed as an acceptance of the substitution's performance potential. The State of Arizona agrees that an approval of a substitution will not be unreasonably withheld. The contractor agrees to reveal its staffing levels by function, including resumes, upon request by the State at any time during the contract.

13. Subcontracts: (See Uniform Terms and Conditions, Paragraph 5B, Subcontracts.) The contractor may, with the consent of the State, enter into written subcontract(s) for performance of certain of its functions under the contract. The State Procurement Office prior to the effective date of any subcontract must approve subcontractors in writing.

13.1 No subcontract which the contractor enters into with respect to performance under the contract shall in any way relieve the contractor of any responsibility for performance of its duties.

13.2 The contractor shall give the State Procurement Office immediate notice in writing by certified mail of any action or suit filed and prompt notice of any claim made against the contractor by any subcontractor or vendor which in the opinion of the contractor may result in litigation related in any way to the contract with the State.

13.3 Contractor shall incorporate, by reference, all requirements, terms, and conditions of this contract (flow-down, See Special Terms and Conditions, Paragraph 30, Flow-down.)

14. Requirements Contract

14.1 This is a requirements contract for the services specified and effective for the period stated. The quantities of services specified are estimates only and are not purchased by this contract.

14.2 Task Performance shall be made only as authorized by task orders issued in accordance with the Ordering clause. Subject to any limitations elsewhere in this contract, the contractor shall furnish to the Agency services specified and called for by task orders issued in accordance with the Ordering clause.

14.3 Any order issued during the effective period of this contract and not completed within that period shall be completed by the contractor within the time specified in the task order. Task orders may be amended.

15. Indefinite Quantity

15.1 This is an indefinite quantity contract for the services specified and effective for the period stated. The quantities of services specified are estimates only and are not purchased by this contract.

15.2 Delivery or performance shall be made only as authorized by task orders issued in accordance with the Ordering clause. The contractor shall furnish to the State, when and if ordered, the services specified. There is no limit on the number of task orders that may be issued. The Agency may issue orders requiring performance at multiple locations.

16. Ordering

16.1 Any services to be furnished under this contract shall be ordered by issuance of task orders by the Agency. Such orders may be issued from date of award of the contract through the end of the contract performance period.

17. Changes, Fixed Price

17.1 The procurement officer may at any time, by written order, and without notice to the sureties, if any, make changes within the general scope of this contract in any one or more of the following:

17.1.1 Description of services to be performed;
17.1.2 Time of performance (i.e., hours of the day, days of the week);
17.1.3 Place of performance of the services.
17.1.4 Drawings, designs or specifications when the supplies to be furnished are to be specially manufactured for the State in accordance with the drawings, designs or specifications;
17.1.5 Method of shipment or packing of supplies
17.1.6 Place of delivery.

17.1.7 If any such change causes an increase or decrease in the cost of, or the time required for the performance of any part of the work under this contract, whether changed or not changed by the order, the Procurement officer shall make an equitable adjustment in the contract price, the delivery schedule or both, and shall modify the contract in writing accordingly.

17.2 The Contractor must assert its right to an adjustment under this clause within 30 days from the date of receipt of the written order. However, if the Procurement Officer decides that the facts justify it, the Procurement Officer may receive and act upon a proposal submitted before final payment of the contract.

17.3 Failure to agree to any adjustment shall be a dispute. However, nothing in this clause shall excuse the Contractor from proceeding with the contract as changed.

18. Shipping F.O.B. Destination: Prices shall be F.O.B. DESTINATION to the delivery location designated. Contractor shall retain title and control of all goods until they are delivered and the contract of coverage has been completed. All risk of transportation and all related charges shall be the responsibility of the contractor. All claims for visible or concealed damage shall be filed by the contractor. The State shall notify the contractor promptly of any damaged goods and shall assist the contractor in arranging for inspection.

19. Contract Divisible: If any provision of the contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the State and the contractor shall be relieved of all obligations arising under such provisions; if the remainder of the contract is capable of performance, it shall be fully performed.

20. Titles: Titles of paragraphs used are for purposes of facilitating ease of reference only and shall not be construed to infer a contractual construction of language.

21. Assignment: The contractor shall not assign any interest in the contract and shall not transfer any interest, whatsoever, in the same (whether by assignment or novation) without the prior written consent of the State Procurement Office thereto.

22. Conflict of Interest: No official or employee of the Agency and no other public official of the State of Arizona who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the project shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in this contract or proposed contract.

23. Licenses: Contractor shall maintain in current status all Federal, State, and local licenses and permits required for the operation of the business conducted by the contractor.

24. Disability Acts: Contractor shall comply with the Americans With Disabilities Act of 1990 (Public Law 101-336) and the Arizona Disability Act of 1992 (A.R.S. 41-1492 et. seq.), which prohibits discrimination on the basis of physical or mental disabilities in delivering contract services or in the

employment, or advancement in employment of qualified individuals. Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting __Gecola Ward, telephone: 602.542.9133. Requests should be made as early as possible to allow time to arrange the accommodation.

25. Assignment. The contractor agrees and understands that the contract shall constitute an assignment by the contractor to the State of Arizona of all rights, title and interest in and to all causes of action that the contractor may have under the antitrust laws of the United States or the State of Arizona for which causes of action have accrued or will accrue as the result of or in relation to the goods or services purchased or procured by the contractor in the fulfillment of the contract with the State of Arizona.

26. The contractor represents that it is an independent contractor offering such services to the general public and shall not present himself or his employees to be an employee of the State of Arizona. Therefore, the contractor shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, workmen's compensation, employee insurance, minimum wage requirements, overtime and agrees to indemnify, save, and hold the State of Arizona, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters.

27. Disputes This contract is not subject to arbitration. The State and the Contractor shall meet to discuss and attempt to resolve any dispute. However, should the dispute go unresolved, the contractor shall have the right to pursue the Arizona Procurement Code/Administrative Appeal Process for claims prior to an appeal to the judicial system.

28. Licenses The contractor shall maintain current federal, state and local licenses and permits required for the period of performance of this contract.

29. Default termination (fixed price services).

(a)(1) The State may, subject to paragraphs c and d below, by written notice of default to the contractor, terminate this contract in whole or in part if the contractor fails to—

(i) Perform the services within the time specified in this contract or any extension,
(ii) Make progress, so as to endanger performance of this contract (but see subparagraph (a) (2) below); or
(iii) Perform any of the other provisions of this contract (but see subparagraph (a) (2) below.

(a)(2) The State's right to terminate this contract under subdivisions (1)(ii) and (1)(iii) above, may be exercised if the contractor does not cure such failure within 10 days (or more if authorized in writing by the procurement officer) after receipt of the notice from the procurement officer specifying the failure.

(b) If the State terminates this contract in whole or in part, it may acquire, under the terms and in the manner the Procurement Officer considers appropriate, services similar to those terminated,

and the contractor shall be liable to the State for any excess costs for those services. However, the contractor shall continue the work not terminated.

(c) Except for defaults of subcontractors at any tier, the contractor shall not be liable for any excess costs if the failure to perform the contract arises from causes beyond the control and without the fault or negligence of the contractor. Examples of such causes include (1) acts of God or of the public enemy, (2) acts of the State in either its sovereign or contractual capacity, (3) fires, (4) floods, (5) epidemics, (6) quarantine restrictions (7) strikes, (8) freight embargoes and (9) unusually severe weather. In each instance the failure to perform must be beyond the control and without the fault or negligence of the contractor.

(d) If the failure to perform is caused by the default of a subcontractor at any tier, and if the cause of the default is beyond the control of both the contractor and subcontractor, and without the fault or negligence of either, the contractor shall not be liable for any excess costs for failure to perform, unless the subcontracted services were obtainable from the sources in sufficient time for the contractor to meet the required delivery schedule.

(e) The State shall pay contract price for completed services delivered and accepted. The State may withhold from these amounts any sum the procurement officer determines to be necessary to protect the State against loss because of outstanding liens or claims of former lien holders.

(f) If, after termination, it is determined that the contractor was not in default, or that the default was excusable, the rights and obligations of the parties shall be the same as if the termination had been issued for the convenience of the State. The rights and remedies of the State in this clause are in addition to any other rights and remedies provided by law or under this contract.

30. FLOW-DOWN Contract requirements, terms and conditions (requirements) required by the State that a PRIME CONTRACTOR incorporates into SUBCONTRACTs. These requirements flow-down rights and responsibilities to the subcontractor that ensure the subcontractor will provide adequate assistance or cooperation to enable the prime contractor to meet its contractual requirements with the State. Failure to flow down the requirements may expose the prime contractor to financial risk if the State takes certain actions under the prime contract and the subcontract does not obligate the subcontractor to respond in accordance with those actions.

31. TRAVEL: LODGING, MILEAGE AND PER DIEM (www.gao.state.az.us).
When requested in writing by the Agency to perform work that requires travel, the state will reimburse the contractor in accordance with the current rates specified in the GAO travel policies and procedures applicable to state employee's travel. The contractor shall itemize all claims for lodging, mileage and per diem as allowed by the GAO travel policies and procedures. Information as to the travel policies and procedures is found at www.gao.state.az.us.

32. Audit and Records—Negotiation (A.R.S. Section 35-214)
(a) As used in this clause, "records" includes books, documents, accounting procedures and practices, and other data, regardless of type and regardless of whether such items are in written form, in the form of computer data, or in any other form.
(b) *Cost or pricing data.* If the Contractor has been required to submit cost or pricing data in connection with any pricing action relating to this contract, the Procurement Officer, or an authorized representative of

the Procurement Officer, in order to evaluate the accuracy, completeness, and currency of the cost or pricing data, shall have the right to examine and audit all of the Contractor's records, including computations and projections, related to:

(1) The proposal for the contract, subcontract, or modification;
(2) The discussions conducted on the proposal(s), including those related to negotiating;
(3) Pricing of the contract, subcontract, or modification; or
(4) Performance of the contract, subcontract or modification.

(c) *Comptroller and Auditor General*

(1) The Auditor General and Comptroller of the State of Arizona, or an authorized representative, shall have access to and the right to examine any of the Contractor's directly pertinent records involving transactions related to this contract or a subcontract hereunder.
(2) This paragraph may not be construed to require the Contractor or subcontractor to create or maintain any record that the Contractor or subcontractor does not maintain in the ordinary course of business or pursuant to a provision of law.

(d) *Reports*. If the Contractor is required to furnish cost, funding, or performance reports, the Procurement Officer or an authorized representative of the Procurement Officer shall have the right to examine and audit the supporting records and materials, for the purpose of evaluating –

(1) The effectiveness of the Contractor's policies and procedures to produce data compatible with the objectives of these reports; and
(2) The data reported.

(e) *Availability*. The Contractor shall make available to the State of Arizona at all reasonable times the records, materials, and other evidence described in paragraphs (a), (b), (c), (d), and (e) of this clause, for examination, audit, or reproduction, until 5 years after final payment under this contract.

(1) If this contract is completely or partially terminated, the Contractor shall make available the records relating to the work terminated until 5 years after any resulting final termination settlement; and

(2) The Contractor shall make available records relating to appeals under the Disputes clause or to litigation or the settlement of claims arising under or relating to this contract shall be made available until such appeals, litigation, or claims are finally resolved.

(f) The Contractor shall insert a clause containing all the terms of this clause, including this paragraph (f), in all subcontracts under this contract that exceed $100,000.

(1) That are cost-reimbursement, incentive, time-and-materials, labor-hour, or price-redeterminable type or any combination of these;
(2) For which cost or pricing data are required; or

(3) That require the subcontractor to furnish reports as discussed in paragraph (d) of this clause. The clause may be altered only as necessary to identify properly the Procurement parties and the Procurement Officer under the State prime contract.

33. Definition of Key Words

33.1 SHALL, MUST: Indicates a mandatory requirement. Failure to meet these mandatory requirements may result in rejection of proposal.

33.2 SHOULD, WILL, MAY: Indicates something that is not mandatory but permissible.

34. DISPUTES

(a) Disputes arising under or relating to this contract may be resolved under this clause.

(b) "Claim," as used in this clause, means a written demand or written assertion by one of the Procurement parties seeking, as a matter of right, the payment of money in a sum certain, the adjustment or interpretation of contract terms, or other relief arising under or relating to this contract. A voucher, invoice, or other routine request for payment that is not in dispute when submitted is not a claim. The submission may be converted to a claim under the Act, by complying with the submission requirements of this clause, if it is disputed either as to liability or amount or is not acted upon in a reasonable time**.** A.R.S. Title 41, chapter 23, article 9 and rules adopted thereunder.

(c)

(1) A claim by the Contractor shall be made in writing and, unless otherwise stated in this contract, submitted within 12 months after accrual of the claim to the Procurement Officer for a written decision. A claim by the State against the Contractor shall be subject to a written decision by the Procurement Officer.

(2)

(i) The certification requirement does not apply to issues in controversy that have not been submitted as all or part of a claim.

(ii) The certification shall state as follows: "I certify that the claim is made in good faith; that the supporting data are accurate and complete to the best of my knowledge and belief; that the amount requested accurately reflects the contract adjustment for which the Contractor believes the State is liable; and that I am duly authorized to certify the claim on behalf of the Contractor."

(3) The certification may be executed by any person duly authorized to bind the Contractor with respect to the claim.

(d) The Procurement Officer must, if requested in writing by the Contractor, render a decision within 60 days of the request. For Contractor-certified claims over $100,000, the Procurement Officer must, within 60 days, decide the claim or notify the Contractor of the date by which the decision will be made.

(e) The Procurement Officer's decision shall be final unless the Contractor appeals or files a suit.

(f) If the claim by the Contractor is submitted to the Procurement Officer or a claim by the State is presented to the Contractor, the parties, by mutual consent, may agree to use alternative dispute resolution (ADR). If the Contractor refuses an offer for ADR, the Contractor shall inform the Procurement Officer, in writing, of the Contractor's specific reasons for rejecting the offer.

(g) The State shall pay interest on the amount found due and unpaid from

(1) The date that payment otherwise would be due, if that date is later, until the date of payment. Simple interest on claims shall be paid at the rate, fixed by the Secretary of the Treasury, which is applicable to the period during which the Procurement Officer receives the claim and then at the rate applicable for each 6-month period as fixed by the Treasury Secretary during the pendency of the claim.

(h) The Contractor shall proceed diligently with performance of this contract, pending final resolution of any request for relief, claim, appeal, or action arising under or relating to the contract, and comply with any decision of the Procurement Officer.

35. CONTRIBUTION STRATEGY Any contribution strategy utilized by the State is subject to available funds and review by the Joint Legislative Budget Committee pursuant to A.R.S. 38-658.

36. HEALTH INSURANCE TRUST FUND

36.1 All direct-pay premium payments, agency payroll deductions, University payroll transfers, retirement system premium benefit transfers, and all legislative appropriations are held within the Health Insurance Trust Fund.

36.2 All financial transactions within the Health Insurance Trust Fund will be as directed by A.R.S. 38-651; A.R.S. 38-652; and A.R.S. 38-654

37. PREMIUM COLLECTION REQUIREMENTS

37.1 Premiums are currently collected in arrears equal to one payroll cycle for active agency employees in accordance with the State approved payroll cycle.

37.2 All agency employee premiums are collected through the identified payroll systems for deposit into the Health Insurance Trust Fund each payroll cycle.

37.3 Arizona State University premiums are collected bi-monthly and electronically transferred to the Health Insurance Trust Fund on the 15th and 30th day of each month.

37.4 University of Arizona premiums are collected on the same payroll cycle as State agencies and are electronically transferred with each payroll cycle.

37.5 All retiree payments authorized for check deduction and premium benefit supplements through the identified retirement system are electronically transferred to the Health Insurance Trust Fund each month.

37.6 All eligible active employees not in an active pay status, retirees not receiving a premium benefit subsidy equal to their group health and dental premiums, or any plan members unable to have payroll/disability/pension deductions are authorized to make personal payments directly to the Agency for premium payments.

37.7 Coverage shall be afforded to active employees on approved leave of absence (with or without pay) up to the maximum time periods allowed provided the member continues to pay premiums according to any and all governing Rules established by the Agency for the period of approved leave of absence. Employees may also be able to continue coverage if they are totally disabled or retire, providing premiums are paid.

37.8 The Agency will be solely responsible for all payroll deduction discrepancies, retirement deduction discrepancies, or electronic transfer discrepancies. The Agency is solely responsible for authorization of, refusal of, agreement to, and determination of terms for any premium payment plans or financial arrangements for any eligible employee or retiree enrolled in the ADOA Saguaro Program.

37.9 The Agency will be solely responsible for any and all collection of errant premium payments. Eligible employees or retirees may be subject to collection procedures identified by Agency including, but not limited to, referral to the Attorney General's Office, authorized legal counsel, or collection service agency for all or any unpaid premium amounts.

38. BILLING PROCESS AND FILE SPECIFICATIONS

38.1 The Contractor shall agree that the Arizona Department of Administration (ADOA) shall self-bill any services for administrative services on an electronic file. Exceptions will be reported on a hard copy provided by the ADOA to the Contractor. The ADOA will remit the monthly amount in arrears to the Contractor within the agreed upon time frame established by ADOA.

38.2 The Contractor shall agree to identify any discrepancies and notify ADOA in writing within 45 days after receipt of payment. The Contractor will fully cooperate with ADOA in an effort to resolve any discrepancies and come to a mutually agreed-upon process or resolution

39. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

State and Contractor agree to comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (the "CFR"). In the event of conflicting terms or conditions, this Addendum shall supersede the Contract.

39.1 Definitions. Capitalized terms not otherwise defined in the Contract shall have the meanings given to them in Title 45, Parts 160 and 164 of the CFR and are incorporated herein by reference.

39.2 Use and Disclosure of Protected Health Information. Contractor shall use and/or disclose Protected Health Information ("PHI") only to the extent necessary to satisfy Contractor's obligations under the Contract.

39.3. Prohibition on Unauthorized Use or Disclosure of PHI. Contractor shall not use or disclose any PHI received from or on behalf of State, except as permitted or required by the Contract, as required by law or as otherwise authorized in writing by State. Contractor shall comply with: (a) Title 45, Part 164 of the CFR; (b) State laws, rules and regulations applicable to PHI not preempted pursuant to Title 45, Part 160, Subpart B of the CFR or the Employee Retirement Income Security Act of 1974 ("ERISA") as amended; and (c) State's health information privacy and security policies and procedures.

39.4. Contractor's Operations. Contractor may use PHI it creates or receives for or from State only to the extent necessary for Contractor's proper management and administration or to carry out Contractor's legal responsibilities. Contractor may disclose such PHI as necessary for Contractor's proper management and administration or to carry out Contractor's legal responsibilities only if:

(a) The disclosure is required by law; or

(b) Contractor obtains reasonable assurance, evidenced by written contract, from any person or organization to which Contractor shall disclose such PHI that such person or organization shall:

(i) Hold such PHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person or organization or as required by law; and

(ii) Notify Contractor (who shall in turn promptly notify State) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

39.5. Data Aggregation Services. Contractor may use PHI to provide Data Aggregation Services related to State's Health Care Operations.

39.6. PHI Safeguards. Contractor shall develop, implement, maintain and use appropriate administrative, technical and physical safeguards to prevent the improper use or disclosure of any PHI received from or on behalf of State.

39.7. Electronic Health Information Security and Integrity. Contractor shall develop, implement, maintain and use appropriate administrative, technical and physical security measures in compliance with Section 1173(d) of the Social Security Act, Title 42, Section 1320d-2(d) of the United States Code and Title 45, Part 142 of the CFR to preserve the integrity and confidentiality of all electronically maintained or transmitted Health Information received from or on behalf of State pertaining to an individual. Contractor shall document and keep these security measures current.

39.8. Protection of Exchanged Information in Electronic Transactions. If Contractor conducts any Standard Transaction for or on behalf of State, Contractor shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of Title 45, Part 162 of the CFR. Contractor shall not enter into or permit its subcontractors or agents to enter into any Trading Partner Contract in connection with the conduct of Standard Transactions for or on behalf of State that: (a) changes the definition, Health Information condition or use of a Health Information element or segment in a Standard; (b) adds any Health Information elements or segments to the maximum defined Health Information set; (c) uses any code or Health Information elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standard's Implementation Specification(s); or (d) changes the meaning or intent of the Standard's Implementation Specification(s).

39.9. Subcontractors and Agents. Contractor shall require each of its subcontractors or agents to whom Contractor may provide PHI received from, or created or received by Contractor on behalf of State to agree to written contractual provisions that impose at least the same obligations to protect such PHI as are imposed on Contractor by the Contract.

39.10. Access to PHI. Contractor shall provide access, at the request of State, to PHI in a Designated Record Set, to State or, as directed by State, to an individual to meet the requirements under Title 45, Part 164, Subpart E, Section 164.524 of the CFR and applicable state law. Contractor shall provide access in the time and manner set forth in State's health information privacy and security policies and procedures.

39.11. Amending PHI. Contractor shall make any amendment(s) to PHI in a Designated Record Set that State directs or agrees to pursuant to Title 45, Part 164, Subpart E, Section 164.526 of the CFR at the request of State or an Individual, and in the time and manner set forth in State's health information privacy and security policies and procedures.

39.12. Accounting of Disclosures of PHI.

(a) Contractor shall document such disclosures of PHI and information related to such disclosures as would be required for State to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Subpart E, Section 164.528 of the CFR.

(b) Contractor agrees to provide State or an individual, in the time and manner set forth in State's health information privacy and security policies and procedures, information collected in accordance with Section 11(a) above, to permit State to respond to a request by an individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Subpart E, Section 164.528 of the CFR.

39.13. Access to Books and Records. Contractor shall make its internal practices, books and records relating to the use and disclosure of PHI received from or on behalf of State available to State and to DHHS or its designee for the purpose of determining State's compliance with the Privacy Rule.

39.14. Reporting. Contractor shall report to State any use or disclosure of PHI not authorized by the Contract, by law, or in writing by State. Contractor shall make the report to State's Privacy Official not less than 24 hours after Contractor learns of such unauthorized use or disclosure. Contractor's report shall at least: (a) identify the nature of the unauthorized use or disclosure; (b) identify the PHI used or disclosed; (c) identify who made the unauthorized use or received the unauthorized disclosure; (d) identify what Contractor has done or shall do to mitigate any deleterious effect of the unauthorized use or disclosure; (e) identify what corrective action Contractor has taken or shall take to prevent future similar unauthorized use or disclosure; and (f) provide such other information, including a written report, as reasonably requested by State's Privacy Official.

39.15 Mitigation. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of the Contract.

39.16. Termination for Cause. Upon State's knowledge of a material breach by Contractor of the terms of this Addendum, State shall:

(a) Provide an opportunity for Contractor to cure the breach or end the violation and terminate if Contractor does not cure the breach or end the violation within the time specified by State.

(b) Immediately terminate the Contract if Contractor has breached a material term of the Contract and cure is not possible.

(c) If neither termination nor cure is feasible, State shall report the violation to DHHS.

39.17. Return or Destruction of Health Information.

(a) Except as provided in Section 17(b) below, upon termination, cancellation, expiration or other conclusion of the Contract, Contractor shall return to State or destroy all PHI

received from State, or created or received by Contractor on behalf of State. This provision shall apply to PHI that is in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of the PHI.

(b) In the event that Contractor determines that returning or destroying the PHI is not feasible, Contractor shall provide to State notification of the conditions that make return or destruction not feasible. Upon verification by State that the return or destruction of PHI is not feasible, Contractor shall extend the protections of the Contract to such PHI and limit further uses and disclosure of PHI to those purposes that make the return or destruction not feasible, for so long as Contractor maintains such PHI.

39.18. Automatic Amendment. Upon the effective date of any amendment to the regulations promulgated by HHS with respect to PHI, the Contract shall automatically amend such that the obligations imposed on Contractor as a Contractor remain in compliance with such regulations.

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

1. **Definition of Terms.** As used in these Instructions, the terms listed below are defined as follows:
   A. *"Attachment"* means any item the Solicitation requires an Offeror to submit as part of the Offer.
   B. *"Contract"* means the combination of the Solicitation, including the Uniform and Special Instructions to Offerors, the Uniform and Special Terms and Conditions and the Specifications and Statement or Scope of Work; the Offer and any Best and Final Offers; and any Solicitation Amendments or Contract Amendments; and any terms applied by law.
   C. "*Contract Amendment"* means a written document signed by the Procurement Officer that is issued for the purpose of making changes in the contract.
   D. *"Days"* means calendar days unless otherwise specified.
   E. *"Exhibit"* means any item labeled as an Exhibit in the Solicitation or placed in the Exhibits section of the Solicitation.
   F. *"Gratuity"* means a payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value is received.
   G. *"Offer"* means bid, proposal or quotation.
   H. *"Offeror"* means a vendor who responds to a Solicitation.
   I. *"Procurement Officer"* means the person duly authorized by the State to enter into and administer Contracts and make written determinations with respect to the Contract or his or her designee.
   J. *"Solicitation"* means an Invitation for Bids ("IFB"), a Request for Proposals ("RFP"), or a Request for Quotations ("RFQ").
   K. *"Solicitation Amendment"* means a written document that is authorized by the Procurement Officer and issued for the purpose of making changes to the Solicitation.
   L. *"Subcontract"* means any Contract, express or implied, between the Contractor and another party or between a subcontractor and another party delegating or assigning, in whole or in part, the making or furnishing of any material or any service required for the performance of the Contract.
   M. *"State"* means the State of Arizona and Department or Agency of the State that executes the Contract.

2. **Inquiries**
   A. Duty to Examine. It is the responsibility of each Offeror to examine the entire Solicitation, seek clarification in writing, and check its Offer for accuracy before submitting the Offer. Lack of care in preparing an Offer shall not be grounds for withdrawing the Offer after the Offer due date and time, nor shall it give rise to any Contract claim.
   B. Solicitation Contact Person. Any inquiry related to a Solicitation, including any requests for or inquiries regarding standards referenced in the Solicitation, shall be directed solely to the Solicitation contact person. The Offeror shall not contact or direct inquiries concerning this Solicitation to any other State employee unless the Solicitation specifically identifies a person other than the Solicitation contact person as a contact.
   C. Submission of Inquiries. The Procurement Officer or the person identified in the Solicitation as the contact for inquiries may require that an inquiry be submitted in writing. Any inquiry related to a Solicitation shall refer to the appropriate Solicitation number, page and paragraph. Do not place the Solicitation number on the outside of the envelope containing that inquiry, since it may then be identified as an Offer and not be opened until after the Offer due date and time.

D. Timeliness. Any inquiry shall be submitted as soon as possible and at least seven days before the Offer due date and time. Failure to do so may result in the inquiry not being considered for a Solicitation Amendment.

E. No Right to Rely on Verbal Responses. Any inquiry that results in changes to the Solicitation shall be answered solely through a written Solicitation Amendment. An Offeror may not rely on verbal responses to its inquiries.

F. Solicitation Amendments. The Solicitation shall only be modified by a Solicitation Amendment.

G. Pre-Offer Conference. If a pre-Offer conference has been scheduled under this Solicitation, the date, time and location shall appear on the Solicitation cover sheet or elsewhere in the Solicitation. An Offeror should raise any questions they may have about the Solicitation or the procurement at that time. An Offeror may not rely on any verbal responses to questions at the conference. Material issues raised at the conference that result in changes to the Solicitation shall be answered solely through a written Solicitation Amendment.

H. Persons With Disabilities. Persons with a disability may request a reasonable accommodation, such as a sign language interpreter, by contacting the Solicitation contact person. Requests shall be made as early as possible to allow time to arrange the accommodation.

3. Offer Preparation

A. Forms: No Facsimile or Telegraphic Offers. An Offer shall be submitted either on the forms provided in this Solicitation or their substantial equivalent. Any substitute document for the forms provided in this Solicitation will be legible and contain the same information requested on the forms. A facsimile, telegraphic, mailgram or electronic mail Offer shall be rejected.

B. Typed or Ink; Corrections. The Offer shall be typed or in ink. Erasures, interlineations or other modifications in the Offer shall be initialed in ink by the person signing the Offer. Modifications shall not be permitted after Offers have been opened except as otherwise provided under applicable law.

C. Evidence of Intent to be Bound. The Offer and Acceptance form within the Solicitation shall be submitted with the Offer and shall include a signature by a person authorized to sign the Offer. The signature shall signify the Offeror's intent to be bound by the Offer and the terms of the Solicitation and that the information provided is true, accurate and complete. Failure to submit verifiable evidence of an intent to be bound, such as an original signature, shall result in rejection of the Offer.

D. Exceptions to Terms and Conditions. All exceptions included with the Offer shall be submitted in a clearly identified separate section of the Offer in which the Offeror clearly identifies the specific paragraphs of the Solicitation where the exceptions occur. Any exceptions not included in such a section shall be without force and effect in any resulting Contract unless such exception is specifically referenced by the Procurement Officer in a written statement. The Offeror's preprinted or standard terms will not be considered by the State as a part of any resulting Contract.

1. Invitation for Bids: An Offer that takes exception to a material requirement of any part of the Solicitation, including terms and conditions, shall be rejected.
2. Request for Proposals: All exceptions that are contained in the Offer may negatively affect the State's proposal evaluation based on the evaluation criteria as stated in the Solicitation or result in rejection of the Offer.

E. Subcontracts. Offeror shall clearly list any proposed subcontractors and the subcontractor's proposed responsibilities in the Offer.

F. Cost of Offer Preparation. The State will not reimburse any Offeror the cost of responding to a Solicitation.

G. Solicitation Amendments. Each Solicitation Amendment shall be signed with an original signature by the person signing the Offer, and shall be submitted no later than the Offer due date and time. Failure to return a signed copy of a material Solicitation Amendment may result in rejection of the Offer.

H. Federal Excise Tax. The State of Arizona is exempt from certain Federal Excise Tax on manufactured goods. Exemption Certificates will be prepared upon request.

I. Provision of Tax Identification Numbers. Offerors are required to provide their Arizona Transaction Privilege Tax Number and/or Federal Tax Identification number, if applicable, in the space provided on the Offer and Acceptance Form and provide the tax rate and amount, if applicable, on the Price Sheet.

J. Identification of Taxes in Offer. The State of Arizona is subject to all applicable taxes. Offerors shall indicate taxes as a separate item in the Offer.

K. Disclosure. If the firm, business or person submitting this Offer has been debarred, suspended or otherwise lawfully precluded from participating in any public procurement activity, including being disapproved as a subcontractor with any Federal, state or local government, or if any such preclusion from participation from any public procurement activity is currently pending, the Offeror shall fully explain the circumstances relating to the preclusion or proposed preclusion in the Offer. The Offeror shall include a letter with its Offer setting forth the name and address of the governmental unit, the effective date of this suspension or debarment, the duration of the suspension or debarment, and the relevant circumstances relating to the suspension or debarment. If suspension or debarment is currently pending, a detailed description of all relevant circumstances including the details enumerated above shall be provided.

L. Solicitation Order of Precedence. In the event of a conflict in the provisions of this Solicitation, the following shall prevail in the order set forth below:

1. Special Terms and Conditions;
2. Uniform Terms and Conditions;
3. Statement or Scope of Work;
4. Specifications;
5. Attachments;
6. Exhibits;
7. Special Instructions to Offerors;
8. Uniform Instructions to Offerors.

M. Delivery. Unless stated otherwise in the Solicitation, all prices shall be F.O.B. Destination and shall include all delivery and unloading at the destination(s).

4. Submission of Offer

A. Sealed Envelope or Package. Each Offer shall be submitted to the submittal location identified in this Solicitation, in a sealed envelope or package that identifies its contents as an Offer and the Solicitation number to which it responds. The appropriate Solicitation number shall be plainly marked on the outside of the envelope or package.

B. Offer Amendment or Withdrawal. An Offer may not be amended or withdrawn after the Offer due date and time except as otherwise provided under applicable law.

C. Public Record. Under applicable law, all Offers submitted and opened are public records and must be retained by the State. Offers shall be open to public inspection after Contract award, except for such Offers deemed to be confidential by the State. If an Offeror believes that information in its Offer should remain confidential, it shall stamp as confidential that information and submit a statement with its Offer detailing the reasons that information should not be disclosed. The State shall make a determination on whether the stamped information is confidential pursuant to the Arizona Procurement Code.

D. Non-collusion, Employment, and Services. By signing the Offer and Acceptance Form or other official contract form, the Offeror certifies that:

1. It did not engage in collusion or other anti-competitive practices in connection with the preparation or submission of its Offer; and
2. It does not discriminate against any employee or applicant for employment or person to whom it provides services because of race, color, religion, sex, national origin, or disability, and that it complies with all applicable Federal, state and local laws and executive orders regarding employment.

5. Evaluation

A. Unit Price Prevails. Where applicable, in the case of discrepancy between the unit price or rate and the extension of that unit price or rate, the unit price or rate shall govern.

B. Taxes. Arizona transaction privilege and use taxes shall not be considered when evaluating Offers.

C. Late Offers. An Offer submitted after the exact Offer due date and time shall be rejected.

D. Disqualification. The Offer of an Offeror who is currently debarred, suspended or otherwise lawfully prohibited from any public procurement activity shall be rejected.

E. Offer Acceptance Period. An Offeror submitting an Offer under this Solicitation shall hold its Offer open for the number of days from the Offer due date that is stated in the Solicitation. If the Solicitation does not specifically state a number of days for Offer acceptance, the number of days shall be ninety (90). If a Best and Final Offer is requested pursuant to a Request for Proposals, an Offeror shall hold its Offer open for ninety (90) days from the Best and Final Offer due date.

F. Payment. Payments shall comply with the requirements of A.R.S. Titles 35 and 41, Net 30 days. Upon receipt and acceptance of goods or services, the Contractor shall submit a complete and accurate invoice for payment from the State within thirty (30) days.

G. Waiver and Rejection Rights. Notwithstanding any other provision of the Solicitation, the State reserves the right to:

1. Waive any minor informality;
2. Reject any and all Offers or portions thereof; or
3. Cancel a Solicitation.

6. Award

A. Number or Types of Awards. Where applicable, the State reserves the right to make multiple awards or to award a Contract by individual line items or alternatives, by group of line items or alternatives, or to make an aggregate award, whichever is deemed most advantageous to the State. If the Procurement Officer determines that an aggregate award to one Offeror is not in the State's best interest, "all or none" Offers shall be rejected.

B. Contract Inception. An Offer does not constitute a Contract nor does it confer any rights on the Offeror to the award of a Contract. A Contract is not created until the Offer is accepted in writing by the Procurement Officer's signature on the Offer and Acceptance Form. A notice of award or of the intent to award shall not constitute acceptance of the Offer.

C. Effective Date**.** The effective date of this Contract shall be the date that the Procurement Officer signs the Offer and Acceptance form or other official contract form, unless another date is specifically stated in the Contract.

7. Protests. A protest shall comply with and be resolved according to Arizona Revised Statutes Title 41, Chapter 23, Article 9 and rules adopted thereunder. Protests shall be in writing and be filed with both the Procurement Officer of the purchasing agency and with the State Procurement Administrator. A protest of a Solicitation shall be received by the Procurement Officer before the Offer due date. A protest of a proposed award or of an award shall be filed within ten (10) days after the protester knows or should have known the basis of the protest. A protest shall include:

A. The name, address and telephone number of the protester;

B. The signature of the protester or its representative;

C. Identification of the purchasing agency and the Solicitation or Contract number;

D. A detailed statement of the legal and factual grounds of the protest including copies of relevant documents; and

E. The form of relief requested.

8. Comments Welcome. The State Procurement Office periodically reviews the Uniform Instructions to Offerors and welcomes any comments you may have. Please submit your comments to the State Procurement Administrator, State Procurement Office, 100 North 15th Avenue, Suite 104, Phoenix, Arizona, 85007.

	Special Instructions to Offerors	**State Procurement Office** 100 North 15th Avenue Suite 104 Phoenix, AZ 85007-3223
	SOLICITATION NO.: AD040404	PAGE 82
	Offeror: _____	

YOU ARE ADVISED TO READ THE UNIFORM INSTRUCTIONS TO OFFERORS TO THIS SOLICITATION. THESE SPECIAL INSTRUCTIONS TO OFFERORS SUPPLEMENT THE UNIFORM INSTRUCTIONS TO OFFERORS.

1. Pre-Proposal Conference: If a pre-proposal conference is to be held, it will be indicated on page one (1) of this document. The purpose of the conference will be to clarify the contents of the Request for Proposal in order to prevent any misunderstanding of the State of Arizona's position. Any doubt as to the requirements of the Request for Proposal or any apparent omission or discrepancy should be presented to the State at the conference. The State of Arizona will then determine the appropriate action necessary, if any, and issue a written amendment to the RFP. Oral statements or instructions shall not constitute an amendment to the Request for Proposal.

2. Proposal Opening: Proposals shall be opened publicly at the time and place designated on the cover page of this document. The name of each offeror shall be read publicly and recorded. Prices will NOT be read. Proposals will not be subject to public inspection until after contract award.

3. Offer Acceptance Period: Proposals shall be irrevocable offers for 180 days.

4. Confidential Information: If a person believes that any portion of a proposal, bid, offer, specification, protest or correspondence contains information that should be withheld, then the Procurement Officer shall be so advised in writing (Price is not confidential and will not be withheld). Such material shall be identified as confidential wherever it appears. The State, pursuant to A.A.C. R2-7-104, shall review all requests for confidentiality and provide a written determination.

5. Pricing: Pricing must be submitted in an all-inclusive basis. The State will not reimburse any item other than the all-inclusive rates contained on the Pricing Schedule.

6. Suspension or Debarment Status: If the firm, business or person submitting this offer has been debarred, suspended or otherwise lawfully precluded from participating in any public procurement activity with any Federal, State or Local Government, the bidder or offeror must include a letter with its offer setting forth the name and address of the governmental unit, the effective date of the suspension or debarment, the duration of the suspension or debarment, and the relevant circumstances relating to the suspension or debarment. Failure to supply the letter or to disclose in the letter all pertinent information regarding a suspension or debarment shall result in rejection of the bid or offer or cancellation of a contract. The State also may exercise any other remedy available by law.

7. Suspension or Debarment Certification: By signing the offer section of the Offer and Acceptance page, SPO Form 203, the offeror certifies that the firm, business or person submitting the bid or offer has not been debarred, suspended or otherwise lawfully precluded from participating in any public procurement activity with any Federal, State or Local Government. Signing the offer section without disclosing all pertinent information about a debarment or suspension shall result in rejection of the bid or offer or cancellation of a contract. The State also may exercise any other remedy available by law.

8. OFFEROR'S CONTACTS:

   8.1 All questions regarding this Request for Proposal including technical specifications, SHALL BE SUBMITTED IN WRITING, FAXED, MAILED or E-MAILED to Gecola Ward. (gecola.ward@ad.state.az.us) FAX 602.542.5508. These questions are usually answered by an amendment to the solicitation.

   8.2 Offerors may not contact the employees of the using Agency concerning this procurement while the proposal and evaluation are in process.

9. EVALUATION AND EVALUATION CRITERIA: An award of a competitive sealed proposal shall be made to the responsible offeror whose proposal is determined in writing to be the best value to the State and to be the most advantageous to the State based on the evaluation criteria. Evaluation criteria are listed in relative order of importance. All factors other than cost are significantly more important than cost. If there are sub-factors, they are listed in descending order of importance. Where the same evaluation term is used to describe the relative importance of more than one evaluation factor, those evaluation factors are of equal importance.

10. EVALUATION CRITERIA
   10.1 Claims, reporting and service capabilities (including ability to administer plan designs and coordinate/compile data from other contractors).
   10.2 Ability to comply with the Agency's goals and service/performance standards
   10.3 Company's overall financial status, reputation and qualifications of key personnel
   10.4 Cost effectiveness of overall service

11. PROPOSAL FORMAT: **One (1) original; THREE (3) copies and One (1) electronic copy** (Sent via e-mail to Gecola.Ward@ad.state.az.us and Susan.Strickler@ad.state.az.us) of each proposal should be submitted on the forms and in the format specified in the RFP. The original copy of the proposal should be clearly labeled "**ORIGINAL**". The material should be in sequence and related to the RFP. The State will not provide any reimbursement for the cost of developing or presenting proposals in response to this RFP. Failure to include the requested information may have a negative impact on the evaluation of the offeror's proposal.

The proposal should include at least the following information:

11.1 Experience/Expertise/Reliability of Offeror's Key Personnel: The proposal should contain the following:

11.1.1 The offeror should provide an organizational chart showing the staffing and lines of authority for the key personnel to be used in the project. The relationship of the project leader to management and to support personnel should be clearly illustrated.

11.1.2 The offeror should provide a resume and data related to previous work assignments as may relate to this RFP for each of the key personnel to be assigned to the project. Resumes and data related to previous work assignments should be submitted.

11.1.3 The offeror should identify the relationship between specific key personnel for which resumes have been submitted and the specific tasks or assignments proposed in the method of approach to accomplish the Scope of Work.

11.2 Experience/Expertise/Reliability of the Firm: The proposal should contain the following:

11.2.1 Experience, expertise and reliability of the offeror's organization is considered in the evaluation process. Therefore, the offeror is advised to submit any information, which documents successful and reliable experience in past performances, especially those performances related to the requirements of this RFP.

11.2.2 References should be listed, should be verifiable and should be able to comment on the offeror's related experience. The offeror should submit four (4) references.

11.2.3 The proposal may include any additional information that reflects on the offerors's ability to perform the required services.

11.3 Method of Approach:

11.3.1 The offeror should present a proposed method of satisfying the requirements of the Scope of Work as specified herein. Briefly describe each step of the schedule of events, if applicable, as the proposed plan of action to accomplish the Scope of Work in a sequential manner identifying the specific assignment of key personnel and the time required to complete each step (task).

11.3.2 The offeror may utilize a written narrative plan of work or any other printed technique to demonstrate his ability to satisfy the Scope of Work. The narrative should describe a logical progression of tasks and efforts starting with the initial steps or tasks to be accomplished and continuing until all proposed tasks are fully described. The language of the narrative should be straightforward and limited to facts, solutions to problems, and

plans of proposed action. The usage of technical language should be minimized and used only to describe a technical process.

11.4 Cost: The cost proposal shall be submitted on the Pricing Schedule attached to the RFP. The offeror must provide a firm, fixed all-inclusive price for all requirements set forth in this Request for Proposal. All firm, fixed prices shall be shown on the Pricing Schedule of this RFP, which should be completed, signed, and returned with the offeror's proposal.

12. Contract Award: The State intends to award a contract or contracts resulting from this solicitation to the responsible offeror(s) whose proposal represents the best value after evaluation in accordance with the factors and sub factors in the solicitation**.**

The State may reject any or all proposals if such action is in the State's interest.

The State may waive informalities and minor irregularities in proposals received.

The State intends to evaluate proposals and award a contract without discussions with offerors, except for clarifications. Therefore, the offeror's initial proposal should contain the offeror's best terms from a cost or price and technical standpoint. The State reserves the right to conduct discussions (negotiations) if the procurement officer later determines them to be necessary. If the procurement officer determines that the number of proposals that would otherwise be in the competitive range exceeds the number at which an efficient competition can be conducted, the procurement officer may limit the number of proposals in the competitive range to the greatest number that will permit an efficient competition among the most highly rated proposals. The State reserves the right to make an award on any item for a quantity less than the quantity offered, at the unit cost or prices offered, unless the offeror specifies otherwise in the proposal.

The State reserves the right to make multiple awards if, after considering the additional administrative costs, it is in the Government's best interest to do so.

Exchanges with offerors after receipt of a proposal do not constitute a rejection or counteroffer by the State.

13. Unnecessarily Elaborate Proposals:
Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective response to this solicitation are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate artwork, expensive paper and bindings and expensive visual and other presentation aids are neither necessary nor wanted.

14. Definition of Key Words:

14.1 SHALL, MUST: Indicates a mandatory requirement. Failure to meet these mandatory requirements may result in rejection of proposal.

14.2 MAY, SHOULD, WILL: Indicates something that is recommended but not mandatory. If the offeror fails to provide recommended information, the State may ask the offeror to provide the information or evaluate the proposal without the information.

15. Discussions:

15.1 In accordance with A. R. S. §41-2534, after the initial receipt of proposals, discussions (negotiations) may be conducted with offerors who submit proposals determined to be reasonably susceptible of being selected for award.

15.2 The State may seek written clarification of proposals from offerors, if necessary. The State may also request offerors attend evaluation committee meetings to provide clarification or unresolved questions after seeking written clarifications.

16. RESERVED

17. There are approximately 51,000 active employees and 8,600 retirees currently participating under the State Agency's medical and dental program. The current and historical enrollment by insurance carrier, county and plan design for both actives and retirees is available on the Informational Data Library (Library) website. Please contact Oscar.Mendez@ad.state.az.us for password and to access Library.

18. The State shall not reduce the coverage other than through modification of co-pays as indicated. Medical and dental plans shall include, at a minimum, those benefits included in current certificates and amendments. The State does not intend to offer its employees any plan that does not include those minimum benefits for each plan design. All proposed plans and program designs shall incorporate at least the minimal benefits with any suggested modifications, alterations, or suggestions for plan or program designs.

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

QUESTIONNAIRE

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GENERAL

Please answer each of the following questions for an integrated plan. Repeat each number and question and make your answers as concise as possible. Your quote will not be considered unless this questionnaire is answered in its entirety.
Confirm that:

A = agree, D = agree with deviations, N = no	A	D	N
The proposed effective date is October 1, 2004.	_____	_____	_____
You are willing to carve out stop-loss and PBM, if the Agency chooses.	_____	_____	_____

Overview

1. Complete the following table regarding your business profile nationally:

Client Type	Number of Clients	Estimated number of enrollees	% of total revenue attributable to this client class
Public-sector employers			
Private-sector employers			
Other (please describe)			

2. Indicate the number of clients you have in Arizona in the following employee group sizes.

	<5,000	5,000-10,000	10,001-25,000	>25,000
# of clients				
Covered lives				

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3. Complete the following grid for your five largest current Arizona client references:

Company Name	Contact Person	Phone Number	Contract Start Date	Number of Employees Covered	Products Purchased

4. Complete the following grid for clients with over 1,000 employees in Arizona who have terminated your services within the two last years:

Company Name	Contact Person	Phone Number	Benefit Offered	Reason for Termination	Termination Date	Number of Employees

5.a If applicable, what are the most recent ratings for your company by the following:

	Rating	Date
Standard and Poor's	_____	_____
Duff and Phelps	_____	_____
A.M. Best	_____	_____
Moody's	_____	_____

5.b Provide supporting documentation for each of the appropriate ratings.

6. Identify if there are any services necessary for the operations of your organization provided by a third party. If so, describe the service and the entity providing the service.

7. Does your organization intend, in the next two years, to merge, sell or reorganize your structure?

8. Complete the following table regarding your medical book of business for each network you are quoting:

Name of network	States and designated regions offered in (please list)	Estimated number of primary enrollees	Number of employers / sponsors	Number of years offered	Estimated size of network nationally

Account Management

9.a Provide an implementation plan identifying key dates for an October 1, 2004 effective date (use separate sheet if necessary).

9.b Who from your organization will manage the implementation process?

10. Please confirm that one account manager will be ultimately responsible for all programs (TPA, Medical, UR/UM, Stop Loss, Pharmacy, etc.). Please identify this individual.

11. Enclose a brief experience resume of the individuals that will be assigned to the service team.

12. For individuals responsible for day-to-day communication, briefly explain their time commitment to other accounts.

13. Describe the account servicing approach and address the following:
    a. Responsibilities of the day-to-day contact
    b. Problem resolution process
    c. Title/level with problem resolution authority
    d. Year-end plan performance analysis
    e. Monitoring account service satisfaction

14. You agree to provide assistance during the implementation process (including but not limited to informed support at employee meetings) and be available on a regular basis (to be determined) for meeting with ADOA's benefit staff to cover all aspects of implementation and discuss ongoing issues.

15. Please confirm you will assist in developing ADOA's SPDs prior to distribution.

16. Please confirm you agree to provide a designated ADOA Member Services phone line.

17. Please confirm you agree to furnish up to four (4) full-time customer service representatives at the Agency.

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18. Please confirm you will comply with ERISA claim appeal procedures, including responding to the first two appeals.

19. Please confirm you will customize the ID card to include any carve-out plan information, such as pharmacy. Costs for customization are included in your quoted rates.

Funding

20. Describe the financial mechanics of the plan.

21. Explain your standard banking arrangements.

22. What is your standard policy regarding frequency and method of deposits to back account to cover benefit checks issued?

23. What is the format and frequency of financial accounting reports?

24. Do you use the Automated Clearing House (ACH) wire transfer system? If not, please explain.

25.a Whose bank is used?
25.b Whose checks are issued?
25.c Who issues the checks?
25.d Are deposits required when checks are written or when cleared?

26. Are there other banking charges not identified in the proposal?

27. Are there initial set-up charges in addition to ongoing monthly bank charges?

28. Who will be responsible for bank reconciliation's on cleared checks or drafts? How flexible are these requirements?

Other

29. How many days' lead time do you typically require for initial set-up?

30. Do you offer electronic funds transfer (EFT) / direct deposit for participants and providers?

31. What is the average turnaround time from receipt of a reimbursement request to check issuance?

32. How frequently and when do you provide account statements to participants? How frequently and when do you provide account statements to the client?

33. Do you offer "debit cards" or a similar product for participants to withdraw funds from their account? If so, please describe capabilities and any requirements in detail.

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CLAIMS ADMINISTRATION, MEMBERSHIP AND BILLING

Please answer the following questions in your proposal by providing information specific to the service center(s) and systems proposed for the State of Arizona. Please identify any differences by site or products. If no differences are identified, we will assume that your answer applies to all products and sites.

General

1. List the services which are included in your normal "full service" Administrative Services Contract charges.

2. What services are provided at an extra charge, and how is the extra charge calculated?

Claims Administration and Processing

3. Where is the service center located that would handle the State of Arizona's claims and customer service (be specific for each coverage)? What are the hours of operation for the claim processing and customer service operation?

4. Identify any intentions of the service center moving within the next three years.

5. Regarding UCR:

   a. How do you define UCR?
   b. Describe database used to develop UCR profiles (e.g., HIAA, MDR, in-house).
   c. What types of services are subject to UCR determinations?
   d. What percentile is used?
   e. Can the percentile be changed for the State of Arizona?
   f. How frequently do you update your UCR profiles?
   g. Do UCR allowances differ between in-network (or in service area) and out of network (or out of service area)?

6. Please describe your COB procedures. For example:

   a. Do you send annual verification letters?
   b. What information does your system maintain on spouse's employment, date of birth, other coverages, etc., for COB purposes?
   c. Do you have computer edit checks or triggers to initiate COB application? What are they?
   d. Do you investigate all possible COB claims, regardless of the claim amount? If not, what is the breakpoint?

7. What is your average COB recovery rate for the last two years? Please describe how the rate is calculated.

8. Please describe your third party subrogation policy. What is the estimate of savings as a percentage of total paid claims?

9. Do you utilize an outside vendor for overpayment and other recoveries? If yes, what supplier and what do you charge clients for recovery services (e.g., X% of amounts recovered)?

10. Do you have a hospital bill audit program? What are your parameters for identifying claims for potential hospital audit? If performed by an outside supplier, please name the firm(s) used.

11. Do you provide claim and customer service performance reports? What is the frequency of standard reports? What types of reports are provided? Are the reports specific to State of Arizona, or are they on unit-wide or office-wide results?

Systems

12. Please specify the details of the claims software system you currently use. Please explain the genesis of the system, when the system was implemented, when it was last updated, how maintenance functions for claims history and plan provisions are performed, and how soon after plan changes are implemented the system is updated to reflect those changes.
13. Indicate any planned changes in claim processing, eligibility, or any other computer systems in the next 12 to 36 months. If so, specify what and when.
14. Will your claims system automatically track the following without requiring claim examiner intervention:
    - annual deductibles
    - annual out-of-pocket limits
    - annual benefits paid per claimant
    - lifetime maximum for State of Arizona plan benefits
    - exception payments made for any claimant

Please indicate any other circumstances that require manual intervention.

15. Specify the diagnosis and procedure coding used in the claim system (e.g., ICD-9 3-digit, CPT-4, hospital UB-92 revenue codes). Specify the extent of ICD-9 data captured in your system.
16. Comment on your current and planned compliance with requirements for electronic data standards and privacy of patient information (HIPAA).
17. What percentage of medical plan claims auto-adjudicate without requiring handling by claims examiner after claims are initially input via electronic feed or data entry?
18. What percentage of hospital claims are received electronically? What percentage of physician claims are received electronically? Describe your ability to handle electronic claim submissions. For example, are electronic claims from providers electronically fed into your claims system? If not, please explain process for entry into claims system.
19. Do you have computer edit checks to detect duplicate billing and describe the decision process for deciding to pay or deny the claim? What other edits does your system offer?
20. Describe your techniques for identifying and resolving questionable billing practices, including “unbundling” of services and “upcoding”. To what extent can your claim system automatically identify these claims and correctly re-price these charges without processor intervention? Does your system check claim history to identify unbundled services?
21. Are there any contractual arrangements that automatically put the provider at risk for claims unbundling/upcoding practices?
22. Is there a maximum and minimum dollar limit on checks issued? Please define.
23. Does your EOB show the status of the deductible, out-of-pocket and other inside plan limits? Does the EOB show the amount of charges that are the member’s responsibility? Does the EOB indicate

network savings? Identify any amounts that have to be computed by the claim processor in order to appear on the EOB. Please provide a sample EOB.

24. Are all network discounts loaded into your claims system and accessed automatically during claims adjudication? Can you maintain separate rates for State of Arizona providers within the network?

25. Do any of the networks require any claims to be sent out for re-pricing? If yes, please describe.

26. Can your claim system auto-adjudicate claims based on pre-certification, on-line authorization, referrals and provider status?

27. What period of claim history is maintained on-line, and for how long (years/months)? What period of claims history is stored off-line, and for how long? Is claim history updated immediately during claim processing or on a batch basis? Describe if batch basis.

28. Will the system provide diagnosis related group information, and is it capable of segmenting hospital charges and length of stay information?

29. Will the system link interim hospital bills processed separately for data reporting and/or analysis?

30. Using the following table, indicate how automated the following procedures are in the claims adjudication process:

Provision	Completely Automated	Partially Automated	Manual
Deductible calculation			
Out-of-pocket max calculation			
Catastrophic accident/illness			
Eligibility verification			
Benefit maximums			
Applying coordination of benefits			
UCR fee application			
Network provider rate application – facility			
Network provider rate application—professional			
Prompt pay discounts			
History recalculations post claim adjustments			
Unbundling/upcoding prevention			
Pre-existing condition limits			
Post-termination benefit cut-off			
FSA payments			
Duplicate payments			
UR requirements			
Assistant surgeon fees			
2nd and 3rd surgical procedures			
Accident benefits			

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Provision	Completely Automated	Partially Automated	Manual
Benefit waiting periods			
Benefit extension periods (COBRA)			
Dependent student status			
Workers' comp claim screening			
Verify provider is licensed to perform service			
Third party liability screening			

31. Indicate the diagnosis and procedure coding system you utilize.

	Facility		Professional Services	
	Yes	No	Yes	No
By your own diagnostic coding system	_____	_____	_____	_____
By ICD-9-DM	_____	_____	_____	_____
By CPT-4/HIAA Codes	_____	_____	_____	_____
By RVS or CRVS	_____	_____	_____	_____
By Diagnostic Related Groups (DRGs)	_____	_____	_____	_____
By other (please specify)	_____	_____	_____	_____

32. Does your data system automatically produce form letters?

33. Do you have the ability to provide on-line access by the State of Arizona to your claims payment systems?
    - If so, at what cost?
    - With what limitations?

34. ADOA expects that you will mail reimbursement checks directly to employees' homes. Please confirm this.

35. Can a participant check the status of their claim by phone? Over the internet?

36. Briefly describe your system disaster recovery plans.

Implementation

37. Please provide a detailed implementation plan and timeline. Describe responsibilities, due dates, etc. Be specific regarding information that State of Arizona and incumbent vendors will need to provide, including timing and method of data transfer.

38. Provide a detailed list of tape specifications necessary for transmittal of employee eligibility data.

39. Delineate all services to be provided with respect to program implementation.

40. Once you receive eligibility information, how long will it take you to get State of Arizona employees on your system?

Organizational

41. The State of Arizona must have a dedicated claims team and a dedicated customer service team. Please confirm that you will assign a dedicated claims team and customer service team to the State of Arizona. Describe the composition of the teams, including experience levels. Will the teams be 100% dedicated to State of Arizona or share responsibility for other accounts? If not 100% exclusive to State of Arizona, for how many other clients are the teams responsible? Also, what percentage of the State's claims will primary dedicated processors handle? What percentage of the State's calls will primary dedicated customer service reps handle?

42. How do you plan to staff the claims and customer service units for the State of Arizona? Please specify the number of claims processors; customer service representatives; the average length of employment for the processors who will handle State of Arizona's claims? For customer service representatives?

43. Provide an organizational chart of the claim and customer service units that will be assigned to this account. Also, provide names, titles and experience of the management responsible for the claims and customer service teams that will be assigned to the State's account.

44. Identify those individuals who would be responsible for the day-to-day service for this contract. Please provide a summary of each individual's education, experience and years in the industry.

45. What is your employee turnover rate in the past 12 months for claims processors in offices that will handle State of Arizona claims? For customer service representatives?

46. What type of back-up coverage for claims and customer service dedicated staffing can you guarantee when absences occur within the dedicated units? What type of back up will be provided for claims and customer service that you can guarantee when problems arise within your designated office(s)?

Workflow/Auditing Processes

47. Briefly describe the claims and related customer service workflow process, and where processing will be performed from receipt of a claim to final processing (include mail receipt and processing, data entry, claims processing, etc.).

48. What percent of claims do you pend or deny for additional information? What percent of claims do you pend for internal referrals (e.g., higher level technical review and medical review)?

49. What is the claim dollar amount that must have review before release?

50. Which of the following methods do you currently utilize for maintaining client's claim documents (microfilm, imaging, hard copy)? Where do you maintain claims documentation? How long do you maintain claims documentation?

51. How do you monitor unprocessed claim inventory?

52. Are claims quality review result reports produced? How frequently and under what circumstances? Are the results maintained by individual? By client? By office? How are results used?

53. What is the ratio of quality reviewers to claim examiners?

54. Describe your method of selecting claims for internal quality review. Are there any processor actions and/or claim characteristics that automatically trigger review? What percentage of claims per examiner and per data entry clerk is reviewed on a daily basis to assure accuracy of payment?

55. Indicate the average claim payment level that requires a higher supervisory level of review?

56. Comment on your compliance with recent claim procedure rules.

57. What method is used to ensure claims processors cannot update eligibility information?

58. For the service center to be assigned to the State of Arizona, specify the longest backlog in claims turnaround within the last 3 years.

- Under normal business conditions.
- Extraordinary conditions (e.g., change in claim system)

Explain the underlying circumstances as well as the remedy.

59. Indicate the date and results (age, financial accuracy and processing accuracy) of your last independent claims audit.

60. Indicate your ability to recognize fraudulent claims activity.

61. What is your organization prepared to do with fraudulent claims incidents?

62. How do you determine whether any provider charges submitted were for services actually rendered?

63. Describe your claims facilities and procedures, including:

    a) The use and role of medical consultants in reviewing questionable claims.

    b) Measures taken to prevent fraud by your own employees related to claims processing and claim/draft control.

    c) Your guidelines with respect to detection of and action on provider fraud, such as overcharges, unnecessary medical/dental procedures, or multiple procedures to the same area. Are there other cost control programs you utilize?

Customer Service

64. Within the customer service operation, who has overall accountability for resolving a plan member inquiry?

65. Are member and provider calls handled and tracked by same or separate customer service units? Please describe.

66. Do you have a member/customer services department dedicated to retiree groups?

67. What types of inquiries do you document in your call tracking system? What percent of all customer service inquiries are documented in your call tracking system? What reports are available to the State of Arizona?

68. What is the average number of inquiries handled per day per customer service representative?

69. Do you have a formal quality review program to monitor customer service representative performance? Briefly describe.

70. How long does it take CSRs to obtain copies of claims documentation, when it is required to respond to an inquiry? What is the process to obtain documentation?

71. Would telephone calls be answered by a “live person” when Program members call, or will they listen to a prerecorded voice with options available?

72. Who or what area is responsible for handling claim adjustments? Briefly describe your claim adjustment workflow process.

73. What are your claim adjustment turnaround time standards for standard requests? For urgent requests?

74. Who or what area is responsible for handling claim appeals? Briefly describe your claim appeal workflow process.

75. Please confirm that a toll-free telephone line will be available for Saguaro Plan participants. Are there any charges associated with this number?

76. How does your organization accommodate hearing-impaired enrollees with the desire to contact your customer services department? *Check only one*.

    [ ] No special accommodations.
    [ ] TDD
    [ ] Other: Please specify.

77. How does your organization accommodate an enrollee who does not speak English and desires to contact your customer services department? Check only one.

    [ ] No special accommodations.
    [ ] Other- please specify

78. Describe how health services will be authorized and handled in an emergency when the participant is out of town.

79. How does your claim system track family members who choose different providers?

80. How often can members change their provider?

81. Is there a limit on the number of changes allowed per year?

82. Explain in detail how your contract addresses benefits for procedures that begin before the effective date of coverage and continue after the effective date.

83. Briefly describe your complaint call tracking and reporting capabilities.

84. How will you handle situations where a member and their dependents live in separate cities? Please distinguish between temporary situations (e.g. students attending college) and permanent situations (e.g. children residing with a former spouse).

85. For employees/retirees who have impaired children that have been approved by the prior claims administrator for extension of coverage, will you assume that extension? Depending on the individual situation, is it possible to require re-certification only every 3-4 years, rather than annually? Please detail your process.

86. Indicate the acknowledgment which your organization typically provides upon receipt of an appeal.

[ ] Unknown.
[ ] Call enrollee to discuss appeal.
[ ] No special acknowledgement until appeal reply sent.
[ ] Correspond with enrollee to notify of our receipt of appeal.

87. Is it possible for an enrollee/provider who filed an appeal to call your organization to check on the status of the appeal?

[ ] No
[ ] Yes, appeals assigned to certain internal staff to handle.
[ ] Yes, any customer service representative can discuss.
[ ] Yes, if the call is to the department to whom the appeal belongs.
[ ] Other, please specify.

Web Capabilities

88. What are your web capabilities for employees and their families (i.e., ID cards, claims status, provider change, e-visits, health information)?

	Current	10/1/2004
Member Self-Service		
Can members:		
▪ Access provider information?	? Yes ? No	? Yes ? No
▪ Access provider directories?	? Yes ? No	? Yes ? No
▪ Access provider directories with driving instructions?	? Yes ? No	? Yes ? No
▪ Participate in community forums?	? Yes ? No	? Yes ? No
▪ If no, does your Web site link to this type of site?	? Yes ? No	? Yes ? No
▪ Access benefit plan summaries?	? Yes ? No	? Yes ? No
▪ Order replacement ID cards?	? Yes ? No	? Yes ? No
▪ "Talk" to providers (i.e., "Ask-the-Physician")?	? Yes ? No	? Yes ? No
▪ File a claim?	? Yes ? No	? Yes ? No
▪ Download printable versions of claim forms?	? Yes ? No	? Yes ? No
▪ Check claim status?	? Yes ? No	? Yes ? No
▪ Submit appeals?	? Yes ? No	? Yes ? No
▪ Submit inquiries to customer service via email?	? Yes ? No	? Yes ? No

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	Current	10/1/2004
Employer Related Internet Functions		
▪ Verify, change, add, delete member/dependent eligibility.	? Yes ? No	? Yes ? No
▪ Member address changes.	? Yes ? No	? Yes ? No
▪ Review benefit plan information and verify applicable copays.	? Yes ? No	? Yes ? No
▪ Review claim status and determine both the date of receipt and date of processing.	? Yes ? No	? Yes ? No
▪ Communicate on-line through email with both the Franklin claim and management teams.	? Yes ? No	? Yes ? No
▪ Access standard statistical and financial information.	? Yes ? No	? Yes ? No
▪ Access catalogued information on legislative developments.		
▪ Review bank account activity		
▪ Process billing statements.	? Yes ? No	? Yes ? No
▪ Order provider directories.		
▪ Communicate with administrator electronically and interactively.		
▪ Other		
Provider Support		
Can providers:		
▪ Verify in "real-time" the eligibility status of members?	? Yes ? No	? Yes ? No
▪ Create virtual medical records for their patients?	? Yes ? No	? Yes ? No
▪ Access medical history for their patients?	? Yes ? No	? Yes ? No
▪ Access lab values or other encounter data?	? Yes ? No	? Yes ? No
▪ Submit claims?	? Yes ? No	? Yes ? No
▪ Submit pre-certification information/extended LOS information?	? Yes ? No	? Yes ? No
Health Management		
▪ Access disease management program information?	? Yes ? No	? Yes ? No
▪ Access educational information?	? Yes ? No	? Yes ? No
▪ Complete a health risk assessment?	? Yes ? No	? Yes ? No
▪ Develop and save a health profile?	? Yes ? No	? Yes ? No
Plan Sponsor/Employer Support		
▪ Can plan sponsors check customer online?	? Yes ? No	? Yes ? No
▪ Can plan sponsors update eligibility online?	? Yes ? No	? Yes ? No

	Current	10/1/2004
▪ Can plan sponsors create reports online?	? Yes ? No	? Yes ? No

Other

89. Will you provide COBRA services as requested?

90. Will you guarantee that you will maintain compliance with all COBRA rules and regulations?

91. Does your COBRA service include collection and distribution of individual payments to the Agency?

92. Is claims payment released on approval day? Do you batch claims for payment? How frequently are payments released to employees? Providers?

Performance Measurement and Standards

93. How do you measure claims turnaround time (e.g., from claim receipt to process date)? How are the following claims treated in measuring turnaround time?
    a. Internal office referrals
    b. External home office referral
    c. Pending claims (awaiting receipt of additional information)

94. Will you be able to provide computer-produced claims turnaround time reports (at no additional charge to State of Arizona) that document your turnaround on the State of Arizona's plans?

95. What are your performance standards for resolving customer service call inquiries that require research and call backs – specifically:
    a. What percent of calls are resolved at initial contact?
    b. In what number of work days or hours should all calls be resolved (e.g., X% of calls closed within X hours or days)?
    c. What percentage of open calls do you require status callbacks to members whose inquiries are not resolved during initial contact?
    d. Do you require complete resolution of a call that requires follow up action before "closing" call? (e.g., if faxed information is received to enable a claim adjustment, will you keep inquiry "open" until claim adjustment is made?)

96. Please complete the following regarding the claim/customer service facility that would service State of Arizona:

Metric	Do you measure and track? (Yes/No)	Specify your performance goals	Do you provide client-specific, Unit, or Office-wide Results? (specify all that apply)	Are reports available to client? (Yes/No)
Claims quality				
Financial payment accuracy (dollars)				
Payment incidence accuracy				
Overall claims processing accuracy				
Claims turnaround time				
% processed within 14 calendar days				
% processed within 30 calendar days				
Customer service				
Call response time				
Percentage of calls answered within X seconds				
Call abandonment rate				
First call resolution				

97. Please complete the following for the office that will process the State of Arizona's claims:

	Financial Payment Accuracy (Dollars)[1]	Payment Incidence Accuracy Rate[2]		Overall Claims Processing Accuracy Rate[3]	Turnaround time — % of claims processed within 14 calendar days	Turnaround time — % of claims processed within 30 calendar days	Telephone Response Time	Call abandonment rate
2002 Objectives								
2002 Results								
2003 Objectives								
2003 Results								
2004 Objectives								
2004 Year to Date Results								

1 Percentage of audited paid dollars processed without error: Defined as: Total dollars paid accurately (total audited paid dollars minus absolute value of overpayments and underpayments) divided by total audited paid dollars.

2 Percentage of audited claims processed without "payment" error.

3 Percentage of audited claims processed without any type of error, regardless of cause (payment or non-payment error).

Membership and Billing

98. Where do you perform billing functions?

99. Does your billing system have the following capabilities, and are processes primarily system-automated vs. manual?

Function	Yes/No	System-automated or Manual?
▪ Link enrollment information in the billing system to the claims system		
▪ Link employer-specific plan options in the billing system to the claims system		
▪ Pro-rate premium for effective dates other than the first of the month		
▪ Maintain complete billing history for online inquiry and provide historical record of an individual's or employer's elected plan options		
▪ Perform retroactive premium and ASO fee adjustments		
▪ Perform COBRA and leave of absence billing		

100. Indicate if your company has the ability to administer eligibility through electronic transfer. Are you able to provide State of Arizona HR with on-line capabilities (eligibility, claims status, premium billing and payment)? If so, please provide cost and information along with tape specifications.

101. What are your web capabilities for billing administration?

102. What is the average turnaround time between the time you receive ongoing or annual enrollment information and the time the plan member receives an ID card?

103. How is eligibility input and verified on the system? What options for eligibility transfer are available and at what frequency?

104. Please provide a sample ID card.

NETWORK MANAGEMENT

1. Do the credentialing processes for your physician and hospital networks meet current NCQA guidelines?

? Yes ? No

2. Are contracted network providers precluded from balance-billing patients for amounts over and above the negotiated reimbursement amount (i.e., the patient is held harmless)?

? Yes ? No

For the remaining questions, please show your responses in the attached Microsoft Excel workbook templates, Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate. There are 15 counties listed in each spreadsheet. When providing your response at the county level for each network, please make every effort to provide an accurate response.

3. Please provide the total number of the following providers with whom your company has contracts by county. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Number of Providers" to complete your response.

Type	December 2003
PCP	
OB/GYN	
General Surgery	
Cardiology	
Pulmonology	
Other Specialists	
Hospitals	

*PCP includes Pediatrics, Internal Medicine, General Practice, and Family Practice.

4. Please provide your average inpatient hospital costs per day by county. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "IP Hospital CPD" to complete your response.

Bed Type	2002	2003
Medical		
Surgical		
Intensive Care		
Maternity		
Mental Health/Substance Abuse		
Overall Weighted Average (not sum)		

5. What were your average in-network effective discounts by county? Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Network Discounts" to complete your response.

Category	2002	2003
Hospital Inpatient		
Hospital Outpatient		
Other Health		
Physician		

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6. For ADOA's 15 counties, please indicate whether your company leases, rather than owns, the network(s). Indicate the name(s) of the leased network utilized in each market.

7. For ADOA's 15 counties, will all network discounts be passed along to ADOA? Or will a portion be withheld?

8. What were inpatient admissions per 1,000 and days per 1,000 per county? Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Admits and Days per 1,000" to complete your response.

Bed Type	2002		2003	
	Admits/1,000	Days/1,000	Admits/1,000	Days/1,000
Medical				
Surgical				
Intensive Care				
Maternity				
Mental Health/Substance Abuse				
Total				

9. Please provide your average in-network physician cost per unit of service for the networks in each county. All services performed during the visit should be included in the average cost. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "PHY CPV" to complete your response.

Type of Service	2002	2003
Average Cost per Primary Care Visit/Encounter		
Average Cost per Specialist Visit/Encounter		
Average Cost per Surgical Procedure (non-facility)		

10. What were in-network physician visits per 1,000 and surgical procedures per 1,000 for the networks in each county? Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Visits and Surgeries per 1000" to complete your response.

Type of Service	2002	2003
	Visits or Surgeries per 1,000	Visits or Surgeries per 1,000
Primary Care Visits/Encounters		
Specialist		

Visits/Encounters		
Surgical Procedures (non-facility)		

11. Please provide your average in-network Outpatient Facility cost per unit of service for the networks in each county. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "OUTP CPU" to complete your response.

Type of Service	2002	2003
Outpatient Surgery (Facility): Revenue Codes 360-379 & 490-499		
Emergency Room Visit: Revenue Codes 450-459		
Radiology Procedure: Revenue Codes 320-339		
Pathology Procedure: Revenue Codes 300-319		

12. What were Outpatient Facility units per 1,000 for the networks in each county? Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Outpatient Units per 1000" to complete your response.

Type of Service	2002	2003
	Units/1,000	Units/1,000
Outpatient Surgery (Facility): Revenue Codes 360-379 & 490-499		
Emergency Room Visit: Revenue Codes 450-459		
Radiology Procedure: Revenue Codes 320-339		
Pathology Procedure: Revenue Codes 300-319		

13. Please complete the sample fee schedule for each county. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Sample Fee Schedule" to complete your responses to 13, 13a, and 13b.

Current Procedural Terminology (CPT) Code	Procedure	Network Average Reimbursement	
		PPO	EPO
10060	Drainage of skin abscess		
11100	Biopsy of skin lesion		

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Current Procedural Terminology (CPT) Code	Procedure	Network Average Reimbursement	
		PPO	EPO
11750	Removal of nail bed		
12001	Repair superficial wound(s)		
17000	Destroy benign/primal lesion		
17304	Chemosurgery of skin lesion		
19120	Removal of breast lesion		
19125	Excision, breast lesion		
19318	Reduction of large breast		
20550	Inject tendon/ligament/cyst		
20610	Drain/inject, joint/bursa		
22554	Neck spine fusion		
27130	Total hip arthroplasty		
27447	Total knee arthroplasty		
28285	Repair of hammertoe		
28296	Correction of bunion		
29826	Shoulder arthroscopy/surgery		
29877	Knee arthroscopy/surgery		
29881	Knee arthroscopy/surgery		
29888	Knee arthroscopy/surgery		
30520	Repair of nasal septum		
31231	Nasal endoscopy, dx		
31255	Removal of ethmoid sinus		
31575	Diagnostic laryngoscopy		
33533	CABG, arterial, single		
33534	CABG, arterial, two		
36533	Insertion of access device		
43239	Upper GI endoscopy, biopsy		
45378	Diagnostic colonoscopy		
45385	Lesion removal colonoscopy		
58150	Total hysterectomy		

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Current Procedural Terminology (CPT) Code	Procedure	Network Average Reimbursement	
		PPO	EPO
59400	Obstetrical care		
63030	Low back disk surgery		
64721	Carpal tunnel surgery		
66984	Cataract surg w/iol, i stage		
67210	Treatment of retinal lesion		
67228	Treatment of retinal lesion		
69436	Create eardrum opening		
70450	Ct head/brain w/o dye		
70553	MRI brain w/0 & w dye		
71020	Chest x-ray		
71260	Ct thorax w/dye		
72141	MRI neck spine w/o dye		
72148	MRI lumbar spine w/o dye		
72193	Ct pelvis w/dye		
73721	MRI joint of lwr extre w/o d		
74160	Ct abdomen w/dye		
76092	Mammogram, screening		
76805	Us exam, pg uterus, compl		
78465	Heart image (3d), multiple		
80061	Lipid panel		
84443	Assay thyroid stim hormone		
85025	Automated hemogram		
88164	Cytopath tbs, c/v, manual		
88305	Tissue exam by pathologist		
88307	Tissue exam by pathologist		
90806	Psytx, off, 45-50 min		
92014	Eye exam & treatment		
93307	Echo exam of heart		
93510	Left heart catheterization		

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Current Procedural Terminology (CPT) Code	Procedure	Network Average Reimbursement	
		PPO	EPO
97110	Therapeutic exercises		
98940	Chiropractic manipulation		
98941	Chiropractic manipulation		
99203	Office/outpatient visit, new		
99213	Office/outpatient visit, est		
99215	Office/outpatient visit, est		
99232	Subsequent hospital care		
99233	Subsequent hospital care		
99244	Office consultation		
99245	Office consultation		
99396	Prev visit, est, age 40-64		

13.a Approximately what percentage of Medicare's Resource Based Relative Value Scale (RBRVS) do these fees schedules represent for each county? Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Sample Fee Schedule a." to complete your response.

13.b Indicate the percentage of providers reimbursed on this fee schedule for each county. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "Sample Fee Schedule b." to complete your response.

14. Please provide actual medical expenses per member per month (PMPM). The term "member" includes all active employees, retired employees, and surviving spouses and their covered dependents. Refer to Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate, tab "PMPM Expenses" to complete your responses to 11, 11a, and 11b.

Category	2002	2003
Inpatient Hospital		
Outpatient Hospital		
Physician Services: Primary Care		
Physician Services: Specialty Care		
Other Healthcare		
Mental Health and Substance Abuse		
Total Medical Expense		

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Category	2002	2003
Total Administration Expense		

15. For out-of-network claims, please describe your reasonable and customary (R&C) fee profile. How often is it updated? What percentile is used?

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NETWORK ACCESS

1. The analyses outlined below should be performed for all the records in the census data provided in the Data Library.

2. All zip codes in ADOA's geographic service areas must be included in your analyses (i.e., in the applicable denominator).

3. Your response should be one report file with the following sections repeated for each provider type and county:

Title Page
Accessibility Summary: County Employees with Access
Accessibility Detail: County Employees with Access, summarized by three-digit zip code
Accessibility Summary: County Employees without Access
Accessibility Detail: County Employees without Access, summarized by three-digit zip code

4. The above five sections should be repeated for every county and each of the following provider types using the following criteria for determining network access:

Provider Type	Maricopa and Pima County Employees	All Other Counties
Primary Care Physicians	2 physicians in 5 miles	2 physicians in 25 miles
OB/GYNs	2 physicians in 5 miles	2 physicians in 25 miles
General Surgery	1 physician in 25 miles	1 physician in 75 miles
Cardiology	1 physician in 25 miles	1 physician in 75 miles
Pulmonology	1 physician in 25 miles	1 physician in 75 miles
Other Specialists	1 physician in 25 miles	1 physician in 75 miles
Hospitals	1 hospital in 15 miles	1 physician in 100 miles

5. Primary care physicians (PCPs) are defined as pediatricians, internal medicine, general practice, and family practice physicians.

6. Exclude closed practices from analysis.

7. Please do not provide maps or other pages not requested above (only provide summaries by county).

8. Provide detailed electronic .xls files via e-mail, diskette, or CD-ROM.

9. In addition to providing the GeoAccess report files requested above, please also complete the spreadsheet labeled "GeoAccess" in the attached Excel files, Network_Information_PPO.xls and Network_Information_EPO.xls, as appropriate.

10. Please also complete the spreadsheet labeled "PHY Roster" in the attached Excel files, Network_Information_PPO.xls and Network_Information_EPO.xls. Exclude closed practices from this listing.

CARE MANAGEMENT

General Information

Broad Service Capabilities

1. Please describe your service capabilities in each of the following areas:

- Health Risk Management
- Self Care
- Chronic Disease Management
- High Cost Case Management (CM)
- Utilization Review/Management (UM)

Disease Management

2. Indicate the location of all offices/sites with disease management services. Which office will be serving the Agency?

3. Confirm the diseases currently addressed by your disease management programs. Check the appropriate box, identifying whether the program is "in development" or "operational."

	In Development	Operational	Operational Date Month/Year		Total number of eligible lives covered for program	Number of Participants Currently Enrolled	Is program/or portion of program subcontracted?		If yes, name provider and length of relationship
			Actual	Planned			Yes	No	
Arthritis	☐	☐	/	/					
Asthma	☐	☐	/	/					
Chronic Pain Management	☐	☐	/	/					
Congestive Heart Failure (CHF)	☐	☐	/	/					
COPD	☐	☐	/	/					
Coronary Artery Disease (CAD)	☐	☐	/	/					
Depression	☐	☐	/	/					
Diabetes	☐	☐	/	/					
Hypercholesteremia	☐	☐	/	/					
Hypertension	☐	☐	/	/					

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	In Development	Operational	Operational Date Month/Year		Total number of eligible lives covered for program	Number of Participants Currently Enrolled	Is program/or portion of program subcontracted?		If yes, name provider and length of relationship
			Actual	Planned			Yes	No	
Low Back Pain/Musculoskeletal	☐	☐	/	/					
Oncology (specify Breast, Lung, Prostate)	☐	☐	/	/					
Rare Diseases	☐	☐	/	/					
Other: _____									

4. Specify which disease management programs you are proposing for the State's active and pre-65 retiree populations. Check those for retirees and actives separately.

	Actives	Retirees
Arthritis	☐	☐
Asthma	☐	☐
Chronic Pain Management	☐	☐
Congestive Heart Failure (CHF)	☐	☐
COPD	☐	☐
Coronary Artery Disease (CAD)	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Hypercholesteremia	☐	☐
Hypertension	☐	☐
Low Back Pain/Musculoskeletal	☐	☐
Oncology (specify Breast, Lung, Prostate…)	☐	☐
Rare Diseases	☐	☐
Other: _____		

5. Do you communicate with members on specific disease-based programs (check all that apply):

	Yes	No
All members	☐	☐
Target audiences based on population at-risk health assessment	☐	☐
Target audiences based on population at-risk claim/encounter information	☐	☐

6. Do you have the following maternity programs?

	Yes	No
Risk screening first trimester	☐	☐
Risk screening second trimester	☐	☐
Risk screening third trimester	☐	☐
Separate risk screening all three trimesters	☐	☐
Introductory packet for expectant mothers	☐	☐
Educational programs keyed to member needs	☐	☐
Telephone access to nurses specializing in maternal-child issues and high-risk pregnancy	☐	☐
Other	☐	☐
Case management for high-risk pregnancies	☐	☐
Postnatal screening protocols for mother and baby	☐	☐
Incentives for participation	☐	☐
Satisfaction survey	☐	☐
Outcomes reporting package (for customer)	☐	☐

7. What are your future plans with respect to disease management? Describe in detail including expansion of diseases that will be managed (insourced or outsourced), risk reduction programs, link to absence and productivity and other relevant issues.

8. Please describe how your company uses its knowledge and resources available regarding a client's medical utilization, pharmacy utilization, and behavioral health information to direct prevention and early detection of disease programs to improve treatment plans and increase quality of care to members while helping clients control plan costs.

9. List the percentage of your disease management Employer clients by size.

Population Size*	# of Clients	% of Book of Business
Less than 5,000 employees/retirees		%
5,000 – 20,000 employees/retirees		%
20,001 – 50,000 employees/retirees		%
50,001 – 100,000 employees/retirees		%
100,001+ employees/retirees		%
Total		100%

* employees/retirees excluding dependents

10. List the percentage of your disease management clients who are in the following market types:

Market Type	# of Covered Lives	% of Book of Business
Employers – employee populations		%
Employers – retiree populations		%
Managed Care Organizations		%
Carriers or TPAs		%
Provider Groups		%
Medicare Plans		%
Other		%
Total		100%

Care Management

11. Care management is done by:

	Yes	No
Health plan staff	☐	☐
Medical group staff	☐	☐
Contracted organization? If yes, include name.	☐	☐

12. Do you have specialty case management nurses for the following:

Services	Yes	No
Pediatrics	☐	☐
Obstetrics	☐	☐
HIV/AIDS	☐	☐
Mental Health	☐	☐
Substance Abuse	☐	☐

13. Which of the following are required qualifications for care management staff:

Education	Yes	No
Bachelor of Science in Nursing	☐	☐
Advanced Degree (i.e., Master of Science in Nursing)	☐	☐
Case Management Certification	☐	☐
Five years of experience in a clinical specialty area (please identify specific requirements for behavioral health specialists)	☐	☐

_____

_____

_____

Client Experience

14. Please describe the growth of membership for your disease management services by completing the following table (provide participating members by year and define participating):

Eligible/Participating	1998	1999	2000	2001	2002	2003
Arthritis						
Asthma						
Chronic Pain Management						
Congestive Heart Failure (CHF)						
COPD						
Coronary Artery Disease (CAD)						
Depression						
Diabetes						
Hypercholesteremia						
Hypertension						
Low Back Pain/Musculoskeletal						
Oncology (specify Breast, Lung, Prostate…)						
Rare Diseases						
Other: _____						

Total Eligible Members						

15. Please provide the following for current disease management clients:

- Two current disease management client references (name, title, address, company, telephone number, email)
- One terminated disease management client reference (name, address, company, telephone number, email) that we may contact.

Staffing and Structure

16. Provide the staffing structure for your disease management program(s) as related to direct participant contact. Please provide an explanation for turnover rates greater than 10 percent.

Direct Participant Contact	Total # of FTE's	Covered Lives	Staff to Patient Ratio	Required Education & Experience	Average Years of Experience	Annual Turnover	Role in Delivery of Disease Management Program
Physicians							
Pharmacists							
RNs							
Non-RN Counselors							
Allied Health Professionals (Health Educators, Social Workers, Dietitians)							
Account/ Implementation/ Program Management							
Customer Service							
Other: _____							

17. Provide the staffing structure for your disease management program(s) as related to Administration/Operations. Please provide an explanation for turnover rates greater than 10 percent.

Administration/ Operations	Total # of FTE's	Staff to Patient Ratio	Required Education & Experience	Average Years of Experience	Annual Turnover	Role in Delivery of Disease Management Program
Physicians						
Pharmacists						
RNs						
Communications Staff						
Program Evaluation						
Quality Improvement						
IT/IS Staff						

Administration/ Operations	Total # of FTE's	Staff to Patient Ratio	Required Education & Experience	Average Years of Experience	Annual Turnover	Role in Delivery of Disease Management Program
Customer Service						
Finance						
Executives						
Sales & Marketing						
Account Management						

18. What is the average nurse caseload? If it varies by level of acuity, please provide specifics.

19. What is your nurse to manager ratio?

20. Please confirm your approach to staffing in the following instances:

	Yes	No
Do you dedicate staff to specific accounts?		
Do you currently/have you had staff dedicated to other clients?		
Would you dedicate staff to the ADOA account if awarded the business?		
Will you proactively notify ADOA of changes in staff (in advance of change)?		

21. Please indicate your hours of operations (Mountain Standard Time (MST) for the following:

	Hours of Operation (MST)					
	Monday through Friday		Saturday		Sunday	
	From	To	From	To	From	To
Customer Service (live)						
Nurses (Inbound)						
Nurses (Outbound)						
Physicians (Inbound)						
Physicians (Outbound)						
After Hours Support						
Other: _____						
Other: _____						

22. How are calls handled after normal business hours?

23. Provide the number of 800 lines available for customer service.

24. What is the average time on hold?

25. What percent of calls are not taken?

26. Can you provide a unique 800 number for ADOA?

Eligibility

27. Please indicate if there are fees for the following services:

	Yes	No
Initial set up of eligibility data feed capabilities		
Ongoing receipt of eligibility feeds		
Other: _____		

Identification and Stratification

28. How do you use data to identify and stratify participants for your program?

Data	Collection Frequency	Use in identification process	Use in stratification process
? Medical Claims	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered
? Rx Claims	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered
? Mental Health/ Substance Abuse Claims	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered

Data	Collection Frequency	Use in identification process	Use in stratification process
? Non-Occupational Disability Claims	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered
? Occupational Disability Claims	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered
? Health Risk Assessment Data	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered
? Lab Values	? Daily ? Weekly ? Monthly ? Quarterly	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered	? Required data – Primary identifier ? Required data – Secondary identifier ? Optional data ? Not considered

29. How do you use predictive modeling technology to identify individuals who are either in the earlier stages of disease or at risk to develop the disease condition? Please be very specific, especially as it relates to ADOA data.

30. Please provide your criteria (ICD-9 codes, CPT codes, events, and other data) used to identify potential participants for each disease condition.

31. Describe your stratification approach (include process, frequency, strata levels and criteria for level, etc.). How does a participant change strata? What criteria are used? Be specific.

Disease Management Recruitment and Enrollment

32. What percent of potential participants are you unable to reach due to the following?

Reason	Percent
Data Integrity	%
Eligibility	%
Unable to reach	

Good contact information – member doesn't respond Bad contact information – unable to reach	% %
Member doesn't meet program criteria	%
Total	100%

33. What methods and resources are used to find missing and/or incorrect telephone numbers?

34. Describe policy and procedures in place when unable to enroll/solicit participant due to reasons above.

35. Define the meaning of:

a. Eligible:

b. Participant:

c. Disenrolled:

36. What type of enrollment model do you use (opt in/opt out)? And why?

37. How many months after most recent active contact with the program are enrollees no longer considered participants? If different by acuity level, please explain.

38. What is your process for disenrollment (i.e., when is a participant considered disenrolled)? Please state the common reasons why people disenroll or are disenrolled.

39. How do you address and measure participant non-compliance? Please describe your process for follow up.

40. What is your follow-up plan for enrollees that successfully complete the disease management program? Are they contracted to ensure they are not regressing? Do you measure and report on this?

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41. Based on your book of business, please provide estimated prevalence, enrollment, participation and retention rates for each of the disease management programs on which you are proposing for ADOA.

Conditions			Risk Stratification			# Active after 6 months		
Arthritis								
Asthma								
Chronic Pain Management								
Congestive Heart Failure								
COPD								
Coronary Artery Disease								
Depression								
Diabetes								
Hypercholesteremia								
Hypertension								
Low Back Pain/Musculoskeletal								
Oncology (Specify breast, lung…)								
Rare Diseases								
Other								

42. Please provide evidence of two client examples for which you have achieved “best” participation and retention rates and describe reasons for success.

43. What initiatives have you implemented in the last year that contributed the most to increasing participation and retention rates?

44. What types of financial incentives or other active or passive engagement tools do you recommend to enhance participation? Please be specific and also provide evidence of the impact of these incentives.

45. What are you expectations for the State’s population in terms of stratification by condition? How do you expect it to differ for retirees versus actives?

Intervention

46. Indicate the type(s) of interventions and methods utilized to impact behavior change among patients and providers for the following programs:

47. In each of the boxes provided below please indicate one or more of the following acuity levels (L = Low / M = Moderate / H = High)

	Type of Intervention					Method of Delivery				
	General Education	Self Management	Treatment Plan Adherence	Lifestyle/ Behavior Change	Provider Education	Direct Mail	Web-Based	Telephone (Inbound)	Telephone (Outbound)	Face to Face
Arthritis										
Asthma										
Chronic Pain Management										
Congestive Heart Failure										
COPD										
Coronary Artery Disease										
Depression										
Diabetes										
Hypercholesteremia										
Hypertension										
Low Back Pain/ Musculoskeletal										
Oncology (Specify breast, lung…)										
Rare Diseases										
Other										

48. Please indicate the type and frequency of contact you have with participants for each level of disease acuity for your disease management programs.

Type of Contact	Low Acuity	Moderate Acuity	High Acuity
	List Frequency of Contact (e.g., NA, 1x per week, 2 weeks, month, quarter, year or other)	List Frequency of Contact (e.g., NA, 1x per week, 2 weeks, month, quarter, year or other)	List Frequency of Contact (e.g., NA, 1x per week, 2 weeks, month, quarter, year or other)
Introductory packet			
Welcome call			
Educational mailings			
Outbound phone calls			
Face to Face contact at home			
Contact with patient's physician			
Contact while in hospital			
Satisfaction survey			
Quality of life assessment			
Functional capacity assessment			
Other: _____			

49. Confirm the ways in which co-morbid conditions are currently identified.
- ☐ Medical Claims Data (in and outpatient)
- ☐ Rx Claims Data
- ☐ Non-Occupational Disability Claims Data (STD/LTD)
- ☐ Occupational Disability Claims Data (WC)
- ☐ Behavioral Health Claims Data (MH/SA)
- ☐ Health Risk Assessments
- ☐ Self Report
- ☐ Other, specify in 10 words or less

50. Confirm how co-morbid conditions are monitored and treatment plans set up.
- ☐ Referral to Case Manager
- ☐ Referral to Primary Care Physician
- ☐ Referral to Specialist
- ☐ Referral to MCO
- ☐ Referral to Nurse Line

- ☐ Referral to Other (please note):_____
- ☐ Self-Monitoring
- ☐ No Role

51. Are participants assigned to a designated coach/disease manager or can any disease manager handle a case as it comes up?

52. Are the systems programmed to handle co-morbid conditions or is it up to the discretion of the nurse?

53. How is a readiness to change behavioral model used in the delivery of your services? For which type of lifestyle conditions is it used?

54. What methods do you use to facilitate communication among patient, provider and pharmacist?

		Patient - Pharmacist	Provider - Pharmacist
Written Correspondence			
Telephone			
E-Mail			
Information Systems			
Face-to-Face			
Web			
Print Material			
Other, specify in 10 words or less			

55. How do you document, ensure and measure physician program understanding and cooperation?

<u>Reporting</u>

56. What variables do you currently track and evaluate each disease management program?

	ROI*	Rx Claims	Total Med Claims	Diagnosis-Specific Medical Claims	Absenteeism	Occ or Non-Occ Lost Time	At-Work Perform.	Risk Reduction	Clinical Outcomes	Patient Satisfaction	Physician Satisfaction
Arthritis		☐			☐			☐			
Asthma		☐			☐			☐			
Chronic Pain		☐			☐			☐			

Management											
Congestive Heart Failure (CHF)		☐			☐			☐			
COPD		☐			☐			☐			
Coronary Artery Disease (CAD)		☐			☐			☐			
Depression		☐			☐			☐			
Diabetes		☐			☐			☐			
Hypercholesteremia		☐			☐			☐			
Hypertension		☐			☐			☐			
Low Back Pain/Musculoskeletal		☐			☐			☐			
Oncology (specify Breast, Lung, Prostate…)		☐			☐			☐			
Rare Diseases		☐			☐			☐			
Other: _____											

*ROI – Return on Investment defined as program savings divided by program cost.

Quality Improvement

57. Are you accredited by or are you pursuing accreditation with any of the following organizations for DM? Please indicate date of accreditation/date of expected accreditation. List any other awards you've received.

	NCQA	Date	JCAHO	Date	URAC	Date
☐ Arthritis	☐	/	☐	/	☐	/
☐ Asthma	☐	/	☐	/	☐	/
☐ Chronic Pain Management	☐	/	☐	/	☐	/
☐ Congestive Heart Failure (CHF)	☐	/	☐	/	☐	/
☐ COPD	☐	/	☐	/	☐	/
☐ Coronary Artery Disease (CAD)	☐	/	☐	/	☐	/
☐ Depression	☐	/	☐	/	☐	/
☐ Diabetes	☐	/	☐	/	☐	/
☐ Hypercholesteremia	☐	/	☐	/	☐	/
☐ Hypertension	☐	/	☐	/	☐	/

☐ Low Back Pain/Musculoskeletal	☐	/	☐	/	☐	/
☐ Oncology (specify Breast, Lung, Prostate…)	☐	/	☐	/	☐	/
☐ Rare Diseases	☐	/	☐	/	☐	/
☐ Other: _____						

58. How do your systems identify quality of care issues? What types of alerts are built into the system?

59. Is there an automated mechanism to track issues/complaints/grievances to resolution?

60. What is the turnaround time for problem resolution?

61. How many staff members are dedicated to the monitoring of quality of care?

62. Who is responsible for monitoring customer satisfaction?

63. Do you conduct participant satisfaction surveys for your enrollees? If yes, how often? If yes, does the survey encompass satisfaction with claim processing as well as satisfaction with Customer Services? Will you communicate results to ADOA?

64. Would you be willing to participate in and contribute toward the cost of an ADOA specific satisfaction survey?

65. Do you conduct provider satisfaction surveys? If yes, how often? If yes, is the survey conducted by a third party organization? Will you communicate results to ADOA?

66. How often do you meet with physicians to review patient satisfaction levels, clinical and contract issues?

Technology

67. What is the current system platform used to support the delivery of your disease management programs? Address the following in your response: tools used to facilitate the delivery of your programs including data management, program monitoring, tracking and reporting. Is the system owned?

68. Describe the methods used to calculate savings to the client.

69. How often do you perform audits on the patient management system regarding nurse input and clinical coaching with the patient?

70. If you offer other medical management services (i.e., UM, CM, etc), do these service use the same system platform? How does the system facilitate/promote cases being transferred from one program to another?

71. What services are offered on-line to support participants and their physicians in the delivery of your programs? Are these services included in or at additional cost to the proposed DM program? Please include in your response current use and future expansion intentions. Please provide web addresses and ID# for demonstration.

Integration

72. What vendors (i.e., Health plans, PBMs, MH/SA, EAP, and disability vendors) do you work with currently? Please be specific. For each vendor, how many employers do you work on behalf of? What is the working relationship?

Vendor Name	Vendor Type (e.g., Health Plan, PBM, etc.)	# of Employers for whom you work with this Vendor	Nature of the Working Relationship

Utilization Review and Case Management

73. What is the total number of covered lives under your utilization management program(s)?

74. Who is the Medical Director of the program? What are his/her qualifications? How much of his/her time is dedicated to the UR program?

75. How many members are covered by your UR service per line?

76. What criteria do you use to assign initial lengths of stay? Are these criteria adjusted by region, age, sex, etc?

77. What is the maximum initial length of stay (LOS) that can be approved by a nurse review?

78. What circumstances initiate a referral to the Medical Director or a physician reviewer? What are the criteria for these referrals? How is it determined which physician reviewer will review the case?

79. On average, what percentage of hospital inpatient review cases are referred for physician review at some point during the review process?

80. In what percent of the cases reviewed by physician reviewers result in direct contact with the treating physician?

81. Is the UR data system capable of capturing the following information?

	Yes	No
date of initial authorization request		
date of pre-determination decision		
date(s) of concurrent review		
date(s) of concurrent review decision(s)		
services approved and denied		
days/services initially/subsequently requested		
days/services initially/subsequently approved/denied		
service classification (elective/emergency)		

82. Indicate the specific medical/surgical criteria/guidelines used to conduct utilization review in both the inpatient and outpatient areas utilizing the format below. Check all appropriate areas.

Criteria	Inpatient		Outpatient	
	Yes	No	Yes	No
A. Milliman and Robertson	?	?	?	?
B. Interqual	?	?	?	?
C. Optimed	?	?	?	?
D. Internally developed	?	?	?	?
E. Other: (indicate specific criteria) [100 characters]	?	?	?	?

83. Please specify what accreditation you possess.

84. Does your UM process include the following determinations?
    a. Eligibility

    ? Yes ? No

85. What is the frequency of eligibility verification? Outline the process in detail.

    b. Benefit coverage

    ? Yes ? No

c. Appropriateness of treatment

? Yes ? No

d. Appropriateness of site

? Yes ? No

e. Inpatient admission classification:

? Elective: Not medical necessity (e.g. cosmetic surgery)
? Urgent: Medical necessity (e.g. MRI for back injury)
? Emergency: Medical necessity (e.g. heart attack)

86. Please provide the following statistics:

Rates	2002	2003	Book of Business
Quarterly admissions per 1000 for the prior 12 months			
Annual admissions per 1000 for the prior 12 months			
Bed days/1000			
Average length of stay			
Number and percent of 24 hour admits			
Number and percent of readmission within 60 days			
Percent of diverted admissions			
Percent of total PMPM for inpatient care (trend adjusted)			
Savings from decrease in present of total PMPM for inpatient care less offset cost for ambulatory increases			

87. What is your utilization management nurse and physician reviewers' turnover rate?

? Less than 5%
? 5 – 10%
? 11 – 25%
? 26 – 50%
? Over 50%
? Do not have this data

88. What are the utilization management program's hours and days of operation?

Monday - Friday _____AM to _____PM EST
Saturday _____AM to _____PM EST
Sunday _____AM to _____PM EST

89. What is your nurse to participant ratio relative to the specific severity levels for case management?

Nurse to Participant Ratio		
Low	Moderate	High

90. Are any nurse reviewers on call after hours?

? Yes ? No

91. Are any physician advisors or medical director(s) on call after hours?

? Yes ? No

92. Do you require physician advisors to be board certified? (Check one)

? Yes
? Yes, and matched by medical specialty to each case
? No

93. Is there a formal panel of physician specialists to review cases?

? Yes ? No

94. Do you currently monitor and report the following data on behalf of the client:

a. The time for UM call resolution (number of hours from time of call to problem resolution)?

? Yes ? No

b. If yes, what is the standard? In hours?

? 24 hours
? 48 hours
? One week
? Other:

c. What is the average time for resolutions that occurred year-to-date and in the past 12 months?

In hours? _____ YTD _____ 12 months

95. Call abandonment rate?

? Yes ? No

? If yes, what is the standard – per hour, per day, per month?

? What is your actual abandonment rate for the past 12 months for each of these standards provided above?

96. What is your average time between initial point of contact and start of the UM program?

97. Do you monitor and report the processing time for UM requests?

? Yes ? No

98. How often are authorizations reported to claims?

? Daily
? Weekly
? Monthly

Concurrent Stay Review and Discharge Planning

99. Is inpatient concurrent review conducted:

? Telephonically
? Onsite
? Both

100. Do you have an automated UM system?

? Yes ? No

If yes, complete the checkbox below:

Does the system have the following capability:	Response	
Display hospital activity for the last six months?	? Yes	? No
Document relevant patient history?	? Yes	? No
Generate lists for callbacks, follow-up calls, incomplete cases, etc?	? Yes	? No
Track and flag physicians with aberrant practice patterns?	? Yes	? No
Feature a diagnosis code using ICD-9 and CPT-4 coding conventions?	? Yes	? No
Provide system linkage between UM, CM, QM and claims?	? Yes	? No
Flag procedures that are not covered due to potential cosmetic, experimental/investigational/research or other?	? Yes	? No
Capture date of initial authorization request?	? Yes	? No
Capture date of predetermination decision?	? Yes	? No
Capture date(s) of concurrent review?	? Yes	? No
Capture date(s) of concurrent review decisions?	? Yes	? No
Capture services (including ICD-9 diagnosis and CPT-4 procedure codes) approved and denied?	? Yes	? No
Capture days/services initially/subsequently requested?	? Yes	? No
Capture days/services initially/subsequently approved/denied?	? Yes	? No
Service classification (elective/emergency)?	? Yes	? No
Send free form messages?	? Yes	? No
Other - Please describe.	? Yes	? No

101. Does your utilization management process include the following determination? (Please check all that apply.)

? Eligibility
? Benefit coverage
? Appropriateness of treatment
? Appropriateness of site treatment
? Admission classification: elective, urgent, emergency

102. What is the maximum number of days allowed between concurrent reviews? (Check one.)

? 0 – 3 days
? 4 – 6 days
? 7 – 10 days
? Greater than 10 days
? Do not have this data

103. Is there any type of interactive decision making process involved in reviews? Please explain?

104. Please describe your end of life care and hospice management programs. Specifically how do the programs interact with the patient, family and physician?

105. What is the turnaround time between case referral and completion of physician review? (Check one)
? 12 hours or less
? 13 – 24 hours
? 25 – 48 hours
? More than 48 hours
? Do not have this data

Case Management

106. Complete the following table, indicating the elements used to identify potential cases for case management:

Elements	Outpatient	Inpatient
Specific computerized trigger diagnoses	? Yes ? No	? Yes ? No
Length of stay	N/A	? Yes ? No
Discharge planning	N/A	? Yes ? No
Readmissions	N/A	? Yes ? No
Emergency room utilization	? Yes	N/A

Elements	Outpatient	Inpatient
	? No	
Claims screening/dollar thresholds	? Yes ? No	? Yes ? No
Pharmacy data	? Yes ? No	? Yes ? No
Physician encounter data by diagnosis	? Yes ? No	? Yes ? No
Laboratory/diagnostic testing results	? Yes ? No	? Yes ? No
UM nurse reviewer identification/referral	? Yes ? No	? Yes ? No
Physician referral	? Yes ? No	? Yes ? No
Member referral	? Yes ? No	? Yes ? No
Health risk appraisals/health status questionnaires	? Yes ? No	? Yes ? No
Psychosocial indicators	? Yes ? No	? Yes ? No

107. Is the case management function integrated with the utilization management function?

? Yes ? No

108. Do you have the ability to manage a case outside of the benefit structure if more cost effective?

? Yes ? No

109. What percentage of enrollees per year is flagged for potential case management?

110. What percentage of enrollees per year is subsequently accepted into your case management program?

111. What percentage of case management cases is referred for physician review on average?

112. For those cases in case management, can you report on clinical and functional improvement and financial savings on a case by case basis?

113. Does the same case manager follow the case throughout its course in case management?

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? Yes ? No

114. Is there a tickler system that alerts a case manager to follow up?

? Yes ? No

115. Does the case manager serve as the primary reviewer if the patient is readmitted to an acute care setting?

? Yes ? No

116. Does the case manager perform file review/follow up to ensure that a patient is not regressing after completion of the case management program?

? Yes ? No

117. Do case managers utilize an automated system for documentation?

? Yes ? No

If yes, indicate which of the following components of the case are documented in the system:

Components		
Date referred/identified	? Yes	? No
Date accepted	? Yes	? No
CM assessment & problem identification	? Yes	? No
Acuity level identification	? Yes	? No
CM individualized plan	? Yes	? No
CM dates of monitoring/communication with patient, family and providers	? Yes	? No
CM evaluation/goal-specific outcomes monitoring	? Yes	? No
Date of closure and reason code	? Yes	? No
Reporting/cost savings analysis	? Yes	? No

118. Are community resources identified and used?

? Yes ? No

119. Do case managers conduct/participate in multidisciplinary team conferences in establishing treatment plans for patients?

? Yes ? No

120. Are member satisfaction surveys conducted on case closure?

? Yes ? No

If yes, what is the overall member satisfaction rate with case management services for the prior 12 months? _____%

121. When assessing cases, is the management based on benefit management or care management or both?

? Benefit management
? Care management
? Both

122. What is the average caseload for case management nurses? (Check one)

? Less than 26
? 26 – 35
? 36 – 50
? 51 – 75
? Greater than 75
? Do not have this data

123. What is your average annual turnover for case managers? (Check one)

? Less than 5%
? 5 – 10%
? 11 – 25%
? 26 – 50%
? Over 50%
? Do not have this data

124. Check which of the following are required qualifications for case management staff:

? Bachelor of Science in Nursing
? Advanced Degree (Master of Science in Nursing, Master of Public Health)
? Case management certificate
? Five years experience in a clinical specialty area
? Yearly continuing education credits in area of clinical specialty

PRESCRIPTION DRUGS

General Questions

Please respond to each of the following questions based on your current PBM relationship(s). If you have more than one PBM relationship available to ADOA, provide a response for each offering. ADOA may choose to "carve-out" prescription drugs from the contract.

Vendor Requirements

This section is a request for confirmation of your ability to meet ADOA's specific standards and conditions.

If your answer is "agree" you acknowledge your willingness to incorporate the specific standards and conditions, as worded in the confirmation, into the final contract. Additionally, you acknowledge that the final financial proposal is reflective of providing these services as defined by ADOA.

If your answer is "no" please provide a detailed explanation, realizing this may be cause for elimination from the bidding process.

Confirm that:

	A = agree N = no	**A**	**N**
1.	You will process prescriptions such that if the member copayment is more than the eligible charge (i.e., discounted ingredient cost plus dispensing fee) of the medication and URC, the member will be required only to pay the eligible charge of the medication at retail and mail.	_____	_____
2.	Rebates must be defined and guaranteed on a per prescription basis, brand and generic, with a share of the rebates after the guarantee.	_____	_____
3.	You will be able to administer the plan design as described in the Web-site.	_____	_____

General Experience

4. Please name all PBMs you currently use.
5. Provide a brief summary of the history of your relationship including how long the relationship has existed and current number of lives you have with each PBM.
   Length of relationship _____
   Number of lives with each PBM _____

6. If you use more than one PBM, please indicate the PBM that you propose for ADOA.

Account Service

7. If the account team for PBM services is different from the medical account team, show the organization of the account service team and senior level officer proposed to serve/manage ADOA's employees in chart format, including titles. Please include the geographical location of each of the team members. If the account team is the same as medical, do not answer questions in this section.

8. Identify how coordination will occur if the medical and prescription drug account service teams are different.
9. Enclose a brief experience resume of the individuals that will be assigned to the account service team and complete the table below:

Title	Name of Person	Years in Current Position	Years with Company	Major Responsibilities	# of Accounts to Support	% of Time Committed to ADOA

10. Describe the account service team and senior sponsor's experience with state employee programs.
11. For individuals responsible for day-to-day communication with members enrolled in the Saguaro Benefit plan, briefly explain their time commitments to other non-Agency accounts. Include the number of lives managed in other accounts as well as the number of accounts.

Customer Service

Please answer the following questions if customer service for PBM services is handled separately from member service for medical. Also differentiate between retail and mail order, as applicable.

12. Where will customer services be handled?
13. What is the size of the customer service center?
14. What is the customer service center's capacity level and at what percent of capacity is it currently functioning?
15. What is the annual rate of turnover of customer service representatives (CSRs) (most recently) for the service center you are proposing?

Turnover Reason	2001	2002	2003
Promotions/Transfers			
Resignations			
Total			
Total as percent of overall CSRs at the Proposed Service site			

16. What are the hours of operations of customer services?
17. For the customer service center that will handle ADOA's account, please provide the following service statistics:

	Standard	2002	2003
Telephone average speed of answer			
Percentage of calls abandoned			
Average waiting time			
Percent of blocked calls			
Average time for written inquiry (electronic or paper) problem resolution from initial notification			
Telephone quality			
Percentage of problems resolved during first call/contact (member does not need to call back)			
Member satisfaction with retail and mail order program			

18. Retail support

    a. Operating hours of member support (live person).
    b. Operating hours of clinical support for retail pharmacists (e.g., prior authorizations)
    c. Operating hours of administrative support for retail pharmacists (e.g., eligibility, vacation overrides)

19. Mail order support
    a. Operating hours of member support (live person)
    b. Operating hours of proposed mail order pharmacy

20. Confirm that you will provide a state specific toll-free telephone number at no additional cost.
21. Do you currently provide automated interactive telephone communication service?
    a. Describe the menu available to callers and indicate if a touch-tone telephone is required or if a voice-response feature is available. If available for our review, please provide the telephone number, and sample ID/login.
22. Do you employ computer-assisted telephone answering capability? If so, is there default to an individual operator? If so, how long does it typically take to reach a live operator?
23. Highlight any distinctive features of service provided to plan participants, such as internet or phone refill services.
24. Provide the following information on participant service staffing:
    a. Briefly outline the basic and ongoing training CSRs receive.
    b. Briefly outline the training CSRs will receive regarding State-specific prescription drug plan elements.
    c. Briefly describe the tools available to CSRs to answer member calls regarding specific claims and/or prescription drug plan elements (e.g., formulary questions, copay for a specific drug).
    d. What are the minimum educational requirements for your CSRs?

25. ADOA is requesting a customer service team that will have dedicated hours in the Pacific or Mountain Time Zone. Will you provide this service? If yes, provide brief information on:
    a. hours of dedicated service unit (indicate if different from regular customer service hours);

b. size and structure of dedicated unit and total number of dedicated CSRs available during hours of operation; and
c. total number and size of accounts that would be serviced by the dedicated unit (including ADOA).

26. Do CSRs have real-time on line access to:
    a. Eligibility,
    b. Claims history/status,
    c. Benefit descriptions,
    d. Status of question/complaint,
    e. Mail order claims status, and/or
    f. Other? (please describe)
27. Based on the potential number of eligible State lives, what is your anticipated customer service unit staffing plan to meet ADOA's needs for both the initial enrollment, and for ongoing customer support? If staffing will vary depending on time of year, please explain how and under what circumstances this will occur.

28. Describe special customer services developed for the following participants:
    a. Seniors,
    b. Spanish speaking,
    c. hearing impaired, and
    d. visually impaired.

29. Confirm that participants will have access to CSRs that can speak fluent Spanish. How many of these representatives are currently on staff? How many of these CSRS will be assigned to the designated ADOA team?
30. Describe the process established to handle written inquiries from participants and plan sponsors, including tracking procedures and follow-up steps.

31. Describe your quality assurance or audit program for customer service and the grievance system that will be in place for participants.
    a. Who is responsible for the quality of the customer service unit?
    b. What monitoring results would be made available to ADOA?
    c. Provide a copy of your customer service audit report that will be provided to ADOA.

32. Describe services available through a Website, including on line resource directories, coverage information, etc. If currently active and available for our review, provide the Website address. Describe any expected enhancements and when you anticipate their availability.

	Is this capability currently available to:	
	Current Members?	Prospective Members?
Online Capability		
Pharmacy Locator		
Plan Design Information		
Formulary Look-up		
Mail Order Refills		
Drug Information		

	Is this capability currently available to:	
Individual Claims History		
Annual Retail and Mail Rx History for Tax Filing		
Pharmacist Querying Capabilities		
Educational Programs/Materials		
Drug Cost Calculator		
Health Assessment Tools		
Other (list)		

33. Describe all methods used to determine participant satisfaction.
    a. Indicate the frequency of surveys.
    b. Indicate if account-specific satisfaction surveys are available.
    c. Provide results of the most recent book-of-business survey.

Mail Order Service

34. Indicate the dispensing facility recommended for this account and briefly explain the reasons for the recommendation (if multiple facilities are available).
35. Provide two references of similar-sized clients using the proposed mail order facility including the following information:

Client	Length of Service	Number of Employees	Contact Name/Tel. #

36. Indicate the level of capacity which could cause delays/problems at the recommended facility and briefly explain the actions which would be taken to avoid such delays/problems.

37. Disclose the following information on the recommended mail order facility:

	2002	2003
Total number of prescriptions dispensed from recommended mail order facility		
Utilization as a percent of capacity		
Number of incorrectly filled, dispensed, labeled, or shipped prescriptions (for whatever reason)		

38. Briefly explain the general reasons or circumstances that resulted in the incorrectly dispensed drugs disclosed above and what was done to correct the errors. Should this happen to ADOA, would ADOA receive compensation for any incorrectly dispensed drugs?
39. Provide the average percent of drug products (i.e., NDC 9) unavailable through your wholesalers for the 12 months ended December 31, 2003. Exclude any recalled drugs and include the names of your primary and secondary drug wholesalers.
40. Explain the process for providing plan members with a short-term retail prescription supply in the case of delayed delivery of their mail order prescription and how the member is notified of the delay.
    a. What criteria are used to determine whether or not a short-term retail supply is authorized?

b. Under what circumstances is the member contribution waived for the retail supply?

41. Describe your process for seeking alternative procurement for drug shortages and how members are notified of specific drug shortages for mail order prescriptions.
42. If the state in which your proposed mail order service facility is located enacts prescription tax legislation (i.e., ADOA's mail order claims become subject to taxation) during the contract term, will you move ADOA's mail order service to another facility located in a state without prescription tax laws? Will you do so at no cost to ADOA?
43. How are plan members notified when a mail order prescription is delayed due to:
    a. A "dirty" prescription requiring intervention with the prescriber or prescriber's agent?
    b. A clean prescription where the delay is due to the PBM's operational, capacity, or drug supply issues?

44. Explain the mail order transition process you recommend for ADOA, including:
    a. Pre-installation testing of customer service, hotline, etc.
    b. Hotline, pre- and post-effective date
    c. Mail order Prescription drug transition assistance for member
    d. Different generic manufacturer used than prior mail order vendor
    e. Other unique servicing ideas

44. ADOA is looking for creative, cost-effective, and appropriate ways to promote and utilize the mail order delivery channel. Please describe options you can provide to ADOA for the proposed mail order designs, including key operational elements/choices:
    a. Disease-based approach,
    b. Incentive mail order plan design, and
    c. Mandatory mail order plan design.

Clinical Management

ADOA is not interested in proposals that will require entry into a shared savings arrangement with the chosen contractor (i.e., savings calculated from clinical programs are charged back to ADOA). If your cost proposal for clinical program support includes a shared savings provision, it is in your best interest to pose an alternative financial arrangement without such a provision.

ADOA is looking for all proposed clinical program guarantees to be guaranteed dollar-for-dollar, and expects to receive 100% of any/all savings achieved in excess of any minimum guaranteed savings. Please complete the information requested in the following table. If your organization proposes to bundle certain clinical programs, please identify clearly which programs are included in the bundle, the fees for the clinical bundle and guaranteed savings. Be sure to provide a specific definition of your savings methodology.

	Program Name	Optional (O) or Mandatory (M)?	Proposed Fees	Proposed Savings	Estimates (E) or Guarantees (G)?		Length of Guarantee (Years)	
					Fees	Savings	Fees	Savings
Basic Concurrent DUR								

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

	Program Name	Optional (O) or Mandatory (M)?	Proposed Fees	Proposed Savings	Estimates (E) or Guarantees (G)?		Length of Guarantee (Years)	
					Fees	Savings	Fees	Savings
(point of sale)								
Basic Retrospective DUR								
Prospective DUR								
Other Enhanced DUR programs (list by name)								
Formulary Management/ Therapeutic Interchanges								
Physician Profiling and Interventions								
Pharmacist Profiling and Education								
Prior Authorization: Administrative Override Clinical Review								
Disease Management								
Case Management								
Compliance Programs								
Other (please specify)								

45. For each of the programs above, please provide a brief overview and any additional materials available.

46. Indicate if savings are guaranteed or estimated, also differentiate between pharmacy and medical cost savings. Provide cost saving calculation methodology.

Financial Proposal

The questions below have been carefully crafted in order to ensure an accurate and fair comparison of competing proposals. Please pay close attention to the wording and ask for clarification, if needed. The guidelines below detail ADOA's preferences for various financial elements. Please keep these guidelines in mind when constructing your financial proposal.

47. Retail brand discount is guaranteed and exclusive of claims with a usual and customary price less than the eligible charge or that are subjected to MAC pricing.

48. Retail generic discount is guaranteed at an overall effective rate (i.e., all generic claims guaranteed at least AWP-50%). If this cannot be met, please be prepared to guarantee the effective discount of your proposed MAC list.

49. Dispensing fees are guaranteed rather than "representative fees" or "national averages."

50. Administrative fees are quoted on a paid claim basis only (i.e., as opposed to paid and denied claims).

51. Mail discounts, brand and generic, are straight percentage guarantees and are excluded from MAC pricing.

52. Guaranteed financial elements should be backed up by a one-for-one reconciliation, such that ADOA is made aware should the actual experience not meet the guarantee.
    If necessary, ADOA will take into account the financial proposals of contractors that do not adhere to these guidelines. For example, quoting estimated discounts will not receive full credit for the quoted discount.

Retail Pharmacy

For the Retail Pharmacy program, provide pricing for your national network options (e.g., broad, restricted, and/or performance-based) of contracted independent and chain pharmacies. Providing access to employees, retirees and dependents in rural areas is a priority of ADOA.

53. What is the name of this network? (if proposing more than one network, e.g., broad and select, complete questions for each network proposed)
54. How many U.S. pharmacies are in this network as of February 1, 2004?
55. Which major chains do not participate in this network?
56. Please provide retail claims pricing for the networks you service based on the information in the spreadsheet. Refer to Rx_Information.xls, tab "Retail Pricing" to complete your response.
57. Please provide a roster of the pharmacies for the broad network you service. Refer to Rx_Information.xls, tab "Rx Locations" to complete your response.

Brand Name Drugs

Brand Name Drugs include all retail single source and multi-source brand name drugs, except those multi-source brand drugs priced as a generic.

58. Only one of the following three (3) formulas can be used to bill the plan sponsor for retail Brand Name Drugs. Please specify which one will be used:
    ____ A rate billed to the plan sponsor equal to the Lower of AWP -X% + $Y dispensing fee, or UCR

____ A rate billed to the plan sponsor of AWP -X% + $Y dispensing fee

____ A pass-thru of contracted rates with an overall annual guarantee* of AWP -X% + $Y dispensing fee

* Will be reconciled at year-end. Will pay/credit ADOA 100% of any shortfall, with ADOA retaining 100% of any additional savings achieved above the minimum guarantee.

59. Confirm that the above formula and the corresponding financial terms submitted by you in the Financial Bid Model will be guaranteed dollar-for-dollar for the contract period.
60. Provide a detailed calculation methodology for the formula proposed. Disclose all components impacting the calculation, including savings directly from AWP discounts, MAC pricing, UCR pricing, therapeutic interchanges, audit program savings, etc…
61. Complete the examples in the following chart as they apply to retail brand drug pricing proposed.

Eligible Charge						
Discounted AWP	Dispensing Fee	Total	U&C Price	Plan Copay	Member Pays	Discounted AWP used in billing formula
$10	$2	$12	$14	$15		
$10	$2	$12	$16	$15		

62. Confirm that the AWP discount percentage proposed:
    - will always be calculated using the AWP for the 11-digit NDC of the actual brand drug dispensed (if not, please specify any/all exceptions)
    - will never be calculated using an average AWP (if not, please specify any/all exceptions)

63. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?
64. How does this billing formula differ from the actual retail pharmacy reimbursement formula?
65. If retail pharmacies are reimbursed at a lower of UCR pricing, provide the following:
    a. the estimated % of brand name Rxs where the UCR price is lower than the reimbursement formula
    b. the estimated impact of UCR pricing as a % of brand name eligible charges
    c. examples of any reports available to demonstrate/validate the impact of UCR pricing

<u>Generic Drugs</u>

Generic Drugs include all retail generic drugs (regardless of whether the drug is priced at the brand discount or as a generic) and multi-source brand drugs priced as a generic.

66. Only one of the following three (3) formulas can be used to bill the plan sponsor for retail Generic Drugs. Please specify which one will be used:

    ____ A rate billed to the plan sponsor equal to the Lower of AWP -X% + $Y dispensing fee, or UCR

    ____ A rate billed to the plan sponsor of AWP - X% + $Y dispensing fee

    ____ A pass-thru of contracted rates with an overall annual guarantee* equal to AWP -X% + $Y dispensing fee

* Will be reconciled at year-end. Will pay/credit ADOA 100% of any shortfall, with ADOA retaining 100% of any additional savings achieved above the minimum guarantee.

67. Confirm that the above formula and the corresponding financial terms submitted by you in the Financial Bid Model will be guaranteed dollar-for-dollar for the three-year contract period.
68. Provide a detailed calculation methodology for the formula proposed for generic drugs. Disclose all components impacting the calculation, including savings directly from AWP discounts, MAC pricing, UCR pricing, therapeutic interchanges, audit program savings, etc…
69. Complete the examples in the following chart as they apply to retail generic drug pricing proposed.

Eligible Charge						
Discounted AWP	Dispensing Fee	Total	U&C Price	Plan Copay	Member Pays	Discounted AWP used in billing formula
$10	$2	$12	$14	$15		
$10	$2	$12	$16	$15		

70. Confirm that the AWP discount percentage proposed:
    - will always be calculated using the AWP for the 11-digit NDC of the actual generic drug dispensed (if not, please specify any/all exceptions)
    - will never be calculated using an average AWP (if not, please specify any/all exceptions)
    - will never be calculated using the AWP for a related multi-source brand drug (if not, please specify any/all exceptions)
71. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?
72. How does this billing formula differ from the actual retail pharmacy reimbursement formula?
73. If retail pharmacies are reimbursed at a lower of UCR pricing, provide the following:
    a. the estimated % of generic Rxs where the UCR price is lower than the reimbursement formula
    b. the estimated impact of UCR pricing as a % of generic eligible charges
    c. examples of any reports available to demonstrate/validate the impact of UCR pricing

<u>Effective Retail Discount Formula</u>

Propose an overall minimum effective retail discount guarantee (AWP - X%) on total brand plus generic drug spend, weighted by dollars, including the impact of MAC and UCR pricing, and excluding dispensing fees.

74. Provide the calculation methodology for this formula.
75. Confirm that the above formula and the corresponding financial terms submitted will be guaranteed dollar-for-dollar for a three-year period.
76. Indicate any aggregate maximum on financial performance penalties.
77. Please provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?

78. Complete this summary table for each retail network proposed in the section above:

Retail			
	Guarantee (G) or Estimate (E)	Length of Guarantee	Amount at Risk and When Penalty is Paid
Name of network _____			
Percent of chain vs. independent pharmacies			
Brand discount percentage off AWP			
Brand dispensing fee per Rx			
MAC generic discount percentage off AWP			
Estimated percentage of generic prescription drugs on MAC[1]			
Estimated percentage of generic dollars on MAC			
Non-MAC generic discount percentage off AWP			
Generic dispensing fee per prescription drug			
Does reimbursement formula include a lower of usual and customary pricing provision for brands and generics? (Yes/No)			
Generic effective discount rate			
Overall effective discount rate			
How does the Brand Discount Formula identified above differ from the actual Retail Pharmacy Reimbursement Formula?			

[1] Defined as generic drugs + multi-source brand drugs on the MAC list.

Retail			
	Guarantee (G) or Estimate (E)	Length of Guarantee	Amount at Risk and When Penalty is Paid
How does the Generic Discount Formula identified above differ from the actual Retail Pharmacy Reimbursement Formula?			
If retail pharmacies are reimbursed at the lower of UCR pricing, provide the following: 1. The estimated percent of brand name Rxs where the UCR is lower than the reimbursement formula. 2. The estimated impact of UCR pricing as a percent of brand name eligible charges. 3. Examples of any reports available to demonstrate the impact of UC R pricing.			

79. Provide a sample report that will be provided to the plan sponsor to demonstrate satisfaction of the guarantees described above and/or to calculate the penalty owed. How frequently is this reconciliation report provided to the client?

80. Does your organization ever use AWP averaging to price retail claims (i.e., averaging AWP across package sizes for a single product)?

    - If so, detail examples and provide your rationale for using this pricing methodology.

81. How can you guarantee for ADOA that using average AWP pricing will not result in more expensive retail prescriptions compared to standard pricing based on the NDC11?

MAC Pricing

83. Describe how your MAC program is developed and maintained and how frequently it is updated. What is your methodology for establishing MAC pricing for individual drugs?

84. For the MAC list you propose for ADOA, provide the following information as of 2/01/04:

	Retail
Name of MAC list	
Estimated Number of Generic Code Numbers (GCNs) on the MAC list.	
Estimated percent of ADOA's retail generic prescriptions that will be MAC'd.	
Estimated % of ADOA's retail generic AWP that will be MAC'd.	
Estimated percent of ADOA's retail multi-source brand prescriptions that will be MAC'd.	
Estimated % of ADOA's retail multi-source brand AWP that will be MAC'd.	
For those generic drugs subjected to MAC pricing, what is the average effective discount off AWP?*	
Based on your book-of-business data, what is the average or effective discount off the generic AAWP (weighted by dollars) for those drugs on the MAC list?	
Will you guarantee this effective discount (f) for ADOA?	

	Retail

Combined with the AWP discount you propose for the broad network in the previous section, what is the estimated overall average effective discount for generic drugs (i.e., all generic drugs, regardless of MAC status)?*	
Will you guarantee this effective discount (h) for ADOA?	
If MAC pricing is proposed for mail order prescriptions (Section E, below), detail any differences compared to the retail responses in (a) – (i) in this table.	

* Exclude multi-source brands from this response.

85. In the attached Excel workbook template, Rx_Information.xls, complete tab "MAC Pricing" for ADOA's top 200 retail generic drugs with your MAC pricing quotes. Please provide the electronic file and a hardcopy of the exhibit in your response. MAC prices used to complete the template should be effective as of February 1, 2004.
    a. Please provide a copy of the proposed MAC list containing all GCNs subjected to MAC pricing in both the hardcopy and electronic versions of your proposal.
    b. Disclose any exceptions or differences in how MAC pricing is administered from pharmacy to pharmacy.

<u>Mail Order Reimbursement</u>

86. Only one of the following two formulas can be used to bill the plan sponsor for Brand Name Drugs. Please specify which one will be used:
    ____ A rate billed to the plan sponsor of AWP - X% + $Y dispensing fee

    ____ An overall annual guarantee* equal to the AWP -X% + $Y dispensing fee.

    * Will be reconciled at year-end. Will pay/credit ADOA 100% of any shortfall, with ADOA retaining 100% of any additional savings achieved above the minimum guarantee.

87. Only one of the following two formulas can be used to bill the plan sponsor for Generic Drugs. Please specify which one will be used:
    ____ A rate billed to the plan sponsor of AWP - X% + $Y dispensing fee

    ____ An overall annual guarantee* equal to the AWP -X% + $Y dispensing fee.

    * Will be reconciled at year-end. Will pay/credit ADOA 100% of any shortfall, with ADOA retaining 100% of any additional savings achieved above the minimum guarantee.

88. Confirm that the above formulas and the corresponding financial terms provided by you will be guaranteed dollar-for-dollar for a three-year period.

89. Provide the following information regarding the AWP source and pricing:
    a. source documents or service providing AWP
    b. frequency of updates to AWP file
    c. use of manufacturer's full 11-digit NDC code to determine AWP
    d. package size basis for typical book of business AWP formula
    e. use of acquisition package size AWP in pricing determination

90. If mail order pricing is based upon the actual dispensed package size, provide an estimate to demonstrate the value compared to discounts based on fixed package size of 100s or pints.

91. If shipping costs are not included in the mail order dispensing fee, define the additional cost.

92. Are the proposed mail order dispensing fees subject to increases due to increases in postal/shipping rates during the contract term?

93. .Are pre-addressed, postage-paid mail order envelopes included in your cost quotation? If not, what is the fee if this service is requested?

94. Complete this summary table for the mail order pricing proposed in the section above:

	Proposed Pricing	Is this an Estimate (E) or a Guarantee (G)	Length of Guarantee (Years)	Amount at Risk
Brand AWP Discount				
Brand Dispensing Fee (per claim)				
MAC Pricing (Yes or No)				
For those drugs on the MAC list, what is the average or effective discount off the generic AAWP (weighted by dollars)				
Estimated % of mail order generic Rxs that will be MAC'd				
Estimated % of mail order multi-source brand Rxs that will be MAC'd				
Non-MAC Generic Discount % off AWP				
Generic Dispensing Fee per Rx				
Postage-paid Return Envelopes				

95. If MAC pricing is proposed detail difference between retail and mail order MAC lists.
    a. Provide the following information regarding the mail order AWP source and pricing:
        i. source document or service providing AWP,
        ii. frequency of updates to AWP file,
        iii. use of manufacturer's full 11-digit NDC code to determine AWP, package size basis for typical book of business AWP formula, and
        iv. use of acquisition package size AWP in pricing determination.

b. If mail order pricing is based upon the actual dispensed package size, provide an estimate to demonstrate the value compared to discounts based on fixed package size of 100s or pints.

96. Do you, or if mail order is outsourced - your associated facilities, repackage drug products for use in filling mail order prescriptions?

    i. If yes, does the AWP for repackaged drugs match the AWP of the same package size of the source labeler?
    ii. If not, how do you establish AWP for your repackaged NDCs?

97. What amount is collected from the member when the mail order copay is greater than the eligible charge?

Specialty Medications

98. Provide a listing of all specialty medications that are eligible for rebates. List what the rebates on these drugs will be for ADOA.

99. Confirm that ADOA can decide which medications on the specialty drug list to implement.

100. Confirm that this can be done with no financial impact to ADOA.

101. Are specialty products available through Retail?

102. Are specialty products available through Mail Order?
103. Are specialty products distributed through Retail reimbursed with the same formula as detailed above in the Retail and Mail Order sections?
    i. If not, please provide the pricing for all products that have specialty pricing (provide applicable AWP discounts and dispensing fees).
104. Are specialty products distributed through Mail Order reimbursed with the same formula as detailed above in the mail order section?
    i. If not, please provide the pricing for all products that have specialty pricing (provide applicable AWP discounts and dispensing fees).
105. Confirm that the pricing provided will be guaranteed dollar-for-dollar for the three-year contract period.
106. Please provide a sample report that will be provided to ADOA to demonstrate satisfaction of this guarantee and/or calculate the penalty owed. How frequently is this reconciliation done?
107. Please describe the procedure you will use to add new drugs to the specialty drug list, as well as the methodology that will be used to set specialty drug pricing for new drugs. How will you provide ADOA advance notice of any additions/changes to the specialty drug list and/or pricing? Once the pricing for new specialty drugs is set, please confirm that the new pricing will be guaranteed for the duration of the contract.

Complete this summary table for the specialty drug pricing proposed in the section above:

Specialty Products			
	Guarantee (G) Or Estimate (E)	Length of Guarantee	Amount at Risk and When Penalty is Paid
Brand discount percentage off AWP			
Brand dispensing fee per prescription drug			
MAC pricing	Yes/No		
MAC generic discount percentage off AWP			
Estimated percentage of generic prescription drugs with MAC price			
Estimated percentage of generic dollars on MAC			
Non-MAC generic discount percentage off AWP			
Generic dispensing fee per prescription drug			
Product distribution	National/Regional		
Shipping charges, if applicable			
Case management (Yes/No)			
Is the discount 'effective' (i.e., inclusive of UCR)?			
How does the Specialty Products Discount Formula identified above differ from the actual Retail Pharmacy Reimbursement Formula?			
Please provide a list of all products subjected to 'specialty' pricing.			
Confirm that you shall provide ADOA with a 30-day notice of price changes.			

Rebates

108. ADOA requires that contractors to state rebates on a "per paid claim" basis. Proposals quoting rebates on any other basis (e.g., "per formulary brand," "per rebateable brand") shall be eliminated from consideration. Complete the following table:

Rebates (Quote on per all prescription basis)			
Rebates SHALL be on a Per Paid Claim Basis, proposals using "per formulary brand" or "per rebateable brand" will not be accepted.	Guarantee (G) Or Estimate (E)	Length of Guarantee	Amount at Risk and When Penalty is Paid
Minimum rebate guarantee—Net Retail Rebate Per Claim			
Minimum rebate guarantee—Net Mail Rebate Per Claim			
Management fee			
Rebate pass-thru in total?	Yes/No		
if yes, percentage pass-thru:	____%		
Rebate pass-thru above minimum?	Yes/No		
if yes, percentage above minimum:	____%		

109. Are these minimum rebate guarantees or flat guarantees? If they are minimum guarantees, confirm that any additional rebate amount is payable to ADOA. Also indicate if the potential for additional rebates is dependent upon State-specific utilization data or book of business utilization data.
110. Detail what percentage of rebates is retained by PBM. Explain how the percentage varies for guaranteed rebates dollars compared to rebates in excess of the guaranteed amount.
111. Describe the frequency and measurement of the formulary rebates. Provide a sample rebate report in your proposal.
112. Detail any escalation clauses you propose for ADOA.
113. Based on the proposed plan design outlined in Appendix A, what formulary or formularies are you proposing for ADOA?
114. Are the rebate guarantees outlined above contingent upon ADOA implementing a specific formulary? If so, which formulary?
115. Are the rebate guarantees outlined above contingent upon ADOA implementing formulary management programs (e.g., therapeutic switch)? If so, describe.
116. Confirm that ADOA can "turn off" any specific therapeutic switches?
117. ADOA wants the flexibility to customize their formulary (e.g., move a drug or entire therapy class into the non-preferred, third tier).
118. Describe your willingness to offer ADOA this flexibility and whether or not customization impacts your PBM service proposal.
119. Describe any formulary modeling capabilities you can offer ADOA to help them evaluate the member, rebate, and plan cost impacts of proposed formulary changes. Detail any additional costs associated with this service.
120. Complete the following table for the proposed formulary or formularies.

	Formulary #1 Name:	Formulary #2 (if applicable) Name

		Formulary #1 Name:	Formulary #2 (if applicable) Name
a	% of all generic NDCs that are classified as formulary drugs*		
b	% of all brand NDCs that are classified as formulary drugs*		
c	% of all multi-source brand NDCs that are classified as formulary drugs*		
d	% of all single-source brand NDCs that are classified as formulary drugs*		
e	Total number of formulary brands (e.g., LIPITOR) without regard to strength (e.g., not LIPITOR 10mg)		
f	Total number of generic NDCs that are classified as formulary drugs		
g	Total number of brand NDCs formulary that are classified as formulary drugs		
h	% of NDCs that are mandatory non-formulary**		
i	What % of prescription claims (book of business) adjudicated as formulary drugs? Please use 3Q 2002 data and 3Q 2002 formulary file		
j	For all analyses above, please indicate the effective date of the formulary file, drug file, and utilization data		

* Note: total of these will not equal 100 (i.e., looking for the percent of total NDCs within each category that are considered formulary products and would carry a formulary copay).

** Please provide a list of any brand name or generic drugs that are <u>mandatory</u> non-formulary for the proposed formulary.

121. Using ADOA's claims detail data provided on the Historical Data Library, please supply the following information

		Formulary #1 Name:	Formulary #2 (if applicable) Name
a.	% of ADOA's generic claims on the formulary		
b.	% of ADOA's generic claims <u>NOT</u> on the formulary		
c.	% of ADOA's brand claims on the formulary		
d.	% of ADOA's brand claims <u>NOT</u> on the formulary		

Library contains a subset of ADOA's retail claims from the first half of 2002. This pricing exercise should use all financial components proposed above–AWP discounts, dispensing fees, MAC list–as well as ADOA's copay structure (see Library) and the formulary you propose. Provide your analyses as an electronic exhibit in your response. If applicable, MAC prices used to answer this question should originate from the list you propose above, with both AWP and MAC prices effective as of November 1, 2002. The following fields, detailed in Exhibit B, should be provided for each claim record: AWP, Eligible Charge (i.e., discounted AWP, U&C, or MAC price), Dispensing Fee, Copay, Plan Cost and Formulary Status).

122. List all instances where a generic drug, regardless of P&T Committee processes, are not covered but the name brand drug is covered. For this question, a generic drug is defined as a medication that has been approved by the FDA through the ANDA process and has at least an 'AB' Orange Book rating. Do not list those medications indicated for seizure disorders, thyroid disease, clotting disorders or CHF. Note, FDB and Medi-Span classifications do not have a bearing on this response. For each instance, provide an explanation for this.

Administration Rates/Fees			
	Guarantee (G) Or Estimate (E)	Length of Guarantee	Amount at Risk and When Penalty is Paid
Network claims processing (please specify basis: paid, paid and denied, or paid, denied, and reversed)			
Out of network and paper processing charge (please specify basis: paid, paid and denied, or paid, denied, and reversed)			
Mail order claims processing			
DUR program ▪ Concurrent ▪ Retrospective ▪ Prospective ▪ Other (list by name)			
Prior authorization (please identify and differentiate between your product options):			
Enhanced utilization management			
Program management tools (e.g., plan design analysis, plan design modeling, on-line reporting)			
Step Therapy			
Disease Management*			

Administration Rates/Fees			
	Guarantee (G) Or Estimate (E)	Length of Guarantee	Amount at Risk and When Penalty is Paid
Compliance Programs*			
Data Reporting: Standard Custom or Ad-Hoc On Line Access			
Customer Service			
Toll-Free Number			
Claim Forms			
Participant Communication Materials: Camera-Ready Art Production Cost			
ID Cards Initial Replacement			
COB Administration			
Other mandatory/required rates/fees, e.g., id cards (please specify)			

Funding and Billing

123. Describe how pharmacy billing will coordinate with medical billing.
124. Describe the claim funding process and address the following points:
    a. payment options
    b. billing frequency
    c. due dates
    d. grace period
    e. late payment procedures
    f. interest penalties
    g. ACH payments and requirements

125. Describe the administration fee billing process and address the following points:
    a. payment options
    b. billing frequency
    c. due dates
    d. grace period
    e. late payment procedures

f. interest penalties

126. Are administrative fees bundled with incurred claims costs or are they billed separately?
127. Describe any additional cost to ADOA due to taxes and address the following points:
   a. type of tax
      - sales
      - usage
      - service
   b. list of states with taxes
   c. level of taxes
   d. applicability of taxes (e.g., state of prescribing, dispensing, or shipment)
   e. estimate of annual tax

128. Include a copy of a standard Agreement to Provide Prescription Benefit Management Services.
129. Verify that your organization will bear the costs of any newly implemented State level taxes that result from the location of your mail order facility. This would not apply to individuals that live in that State, but to those that are charged a tax on ADOA in which the PBM is located. Please refer to ADOA of Missouri Senate Bill No. 1238, legislation for further information.
130. Include a copy of a standard Agreement to Provide Prescription Benefit Management Services.
131. Are there any advance deposit requirements? If so, can they be waived for the ADOA?

Performance Guarantees

132. Do you offer separate performance guarantees for the prescription drug plan? If so, please provide a listing of your standard guarantees.

Formulary Switching

133. List all medications that are switched from a branded medication that has a generic available to a single-source, branded medication (i.e., Zovirax® /acyclovir to Valtrex®).
134. List all brand medications that your organization switched away from at any time in 2003 that are now available generically.
135. List all medications that your organization switched away from at any time in 2003 that are expected to be marketed generically by January 1, 2004.

Implementation Credit or Allowance

136. Discuss any implementation credit or allowance that you are proposing:
   a. the amount,
   b. how it can be used,
   c. when and how it will be paid,
   d. required paperwork,
   e. eligible expenses, and
   f. other limitations.

Other Guarantees

137. Propose additional guarantees as applicable

	Proposal	Is this an	Length of

		Estimate (E) or a Guarantee (G)	Guarantee (Years)
DUR Savings			
Effective AWP discount for drugs on MAC list – Retail			
Generic Dispensing Rate – Retail			
Generic Dispensing Rate – Mail Order			
Generic Substitution Rate – Retail			
Generic Substitution Rate – Mail Order			
Other Proposed Guarantees			

138. For each guarantee list below, provide additional information as applicable:
   a. How the savings or rate is measured. Include applicable formula.
   b. The penalty that will be paid if the guarantee is not met and when it will be paid. Indicate any aggregate maximums.
   c. Provide a copy of the report that will be provided to the client to validate the guarantee.

Other

139. Preferred Drug List - Provide a complete list of preferred and non-preferred drugs that would be subject to the higher copay in a three-tier plan design. Sort this list by therapeutic category. Can ADOA customize this list? This listing should document the targeted drug and the FIRST alternative that is offered to the prescriber. Please use the following format:

Targeted Drug	Therapeutic Class	First Alternative Offered to Prescriber	Additional Alternative Offered to Prescriber	Is this targeted drug scheduled to receive FDA generic marketing approval by 12/31/03? (Y or N)

140. Intervention Process - Describe the process for formulary interventions and other therapeutic switches. Detail the cases where the AWP of the preferred/formulary drug is higher than the AWP of the targeted non-preferred/non-formulary drug. Differentiate these cases between the retail and mail order protocols.
141. Counter-detailing - In addition to the clinical pharmacist assigned to ADOA account, indicate your ability and willingness to provide additional pharmacist support specifically for prescriber counter-detailing within ADOA of Arizona. Provide the level of support you propose (i.e., FTE dedicated to State-specific counter-detailing). Discuss issues other than preferred drug utilization that are targeted by the counter-detailing program (i.e., generic utilization promotion, appropriate length of therapy).
142. Effectiveness - Describe the effect on the net cost per Rx and formulary rebates from prior year with respect to “open formulary” designs.
143. Drug Recall - Describe any mechanisms currently in place to obtain refunds for ADOA on FDA Class 1, recalled medications for State employees. Emphasis should be placed on those drugs that are removed from the market and not those that only have a specific lot(s) removed. Specifically address how your organization addresses this ongoing issue when contracting with the pharmaceutical manufacturers for rebates or other programs.

144. List all prescriber and patient education programs that you would recommend be implemented, and list those programs that are provided as a part of the administration fee together and those programs that you would recommend but have an added charge after the previous programs. Do not list any programs that have a shared savings component.
145. Describe any mechanisms currently in place to obtain refunds for ADOA in the event of class action lawsuit settlements (i.e., Synthroid and Coumadin settlements).
146. List all medications that are available for prior authorization (i.e., clinical criteria developed and available for implementation).
147. Provide the list of drugs and/or therapy classes that you recommend ADOA subject to prior authorization.
148. List the percent of prior authorization requests that are approved (i.e., book of business) for each drug and/or therapy class you recommend.
149. Describe your prior authorization appeals process.
150. Indicate whether or not the appeals process meets ERISA guidelines.
151. Detail any costs associated with processing prior authorization appeals.
152. Indicate whether or not the appeals process meets ERISA guidelines and detail any costs associated with the process.
153. Prior Authorization (PA) Hours of Operations – List the hours of operations for the PA department and the average turnaround time for PA decisions.
154. Detail any formal program in place to notify plan sponsors of new drug developments (i.e., anticipated launch of a blockbuster drug). Provide two to three examples of this type of notification from 2002, if applicable. Does your program provide statistical modeling based on plan sponsor data?

Plan Design

155. Confirm that your proposal adheres strictly to all components of the current plan design described in Exhibit A. ADOA reserves the right for minor modification of this plan design in the future. (See Date Library)
    a. Describe your plan design modeling capabilities and your willingness to assist ADOA in this effort.
        i. Detail any additional costs associated with plan design modeling services.
        ii. ADOA may consider future implementation of coinsurance and additional copay tiers.

    Briefly discuss your modeling capabilities, communications strategy in these areas.
    b. Are any financial elements of your proposal contingent upon ADOA maintaining specific plan design parameters? If yes, describe.
    c. ADOA currently coordinates out-of-pocket maximums with other contractors.

    Confirm your ability to provide prescription claims data to an outside contractor for this purpose at no additional cost to ADOA.
    d. The current pharmacy plan design includes both retail and mail order components, based on a three-tier formulary design, with member copayments of $10/$20/$40 (generic/formulary brand/non-formulary brand) at retail and $20/$40/$80 (generic/formulary brand/non-formulary brand) at mail order [90-day supply].

Plan Design Feature	Retail	Mail Order [90-day supply]
Rx Deductible (None, Integrated w/ Medical, or Separate Rx)	None	

Plan Design Feature	Retail	Mail Order [90-day supply]
Member Coinsurance/Copays:		
Generic	$10	$20
Formulary Brand	$20	$40
Non-formulary Brand	$40	$80
Formulary (open, incentive, closed)	Incentive	
Mandatory Mail Order	N/A	
If mandatory mail order, # of retail fills allowed	N/A	
Out-of-pocket Maximum (None, Integrated with Medical or Separate Rx)	None	
Annual Out-of-Pocket Maximum (Amount per employee or per member)	N/A	
Annual Benefit Maximum (None, Integrated with Medical or Separate Rx)	None	
Annual Benefit Maximum (Amount per employee or per member)	N/A	
Lifetime Benefit Maximum (None, Integrated with Medical or Separate Rx)	None	
Days Supply Limit	30	90

e. Covered Prescription Drugs
   i. Prescription legend drug for which a written prescription Is required
      (1) Insulin, syringes, prefilled insulin cartridges for the blind, oral blood sugar control agents, glucose test strips, visual reading ketone strips, urine test strips, lancets, and alcohol swabs
      (2) A compound medication of which at least one ingredient is a prescription legend drug
      (3) Tretinoin for individuals through age 35
      (4) Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a prescriber
      (5) Oral contraceptives or contraceptive devices, regardless of intended use, except implantable contraceptive devices, such as Norplant
      (6) Prenatal vitamins, upon written prescription
      (7) Injectable drugs or medicines for which a prescription is required, excluding infertility drugs
      (8) Oral infertility drugs

156. Limitations - No payment will be made for expenses incurred:
   a. For non-legend drugs, other than those specified in the “Covered drugs” section.
   b. For experimental drugs or for drugs labeled: “Caution – limited by federal law to investigational use”
   c. For drugs obtained from a non-participating mail order pharmacy
   d. Any prescription filled in excess of the number specified by the Prescriber and dispensed more than one year from the date of the prescriber’s order

e. For more than a 30-day supply when dispensed in any one prescription order through a retail pharmacy
f. For more than a 90-day supply when dispensed in any one prescription order through a mail pharmacy
g. For indications not approved by the Food and Drug Administration
h. For immunizations agents, biological sera, blood, or blood plasma
i. For therapeutic devices or appliances, support garments, and other nonmedicinal substances, excluding insulin syringes
j. For drugs for cosmetic purposes
k. For tretinoin for individuals age 36 and over
l. For medication that is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution that operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
m. For prescriptions that an eligible person is entitled to receive without charge from any worker's compensation or similar law or any public program other than Medicaid
n. For growth hormones and anabolic steroids
o. For nutritional or dietary supplements, antiobesity drugs, or anoreients
p. For contraceptive devices, including implantable contraceptive devices.
q. For prescription vitamins, other than prenatal vitamins, upon written prescription
r. For smoking cessation products
s. For injectable infertility drugs

STOP-LOSS

ADOA may choose to "carve-out" stop-loss out of this contract.

Disclosure/Underwriting

1. Please describe your disclosure requirements for the initial quotation process. Describe in detail how your firm will treat ongoing claims as of the inception date of the contract.

2. The contractor must agree to waive any actively-at-work exclusions at inception. However, does your contract allow you to limit or exclude coverage for individuals who are disabled/receiving treatment that you were not made aware of through this RFP process or that occurred after you were awarded the contract, but prior to the contract effective date?

3. Please describe your renewal rating process. How much credibility will be placed on this client's experience for renewal purposes? Describe your disclosure requirements and how you intend to treat large, ongoing claim cases at renewal. Further verify that once an employee is covered by stop loss they cannot be excluded or have separate deductibles applied under the contract.

4. Is there an aggregate limit on your stop-loss liability for a given claimant? If so, what is it? Is there a dollar limit or percentage on the amount of run-in claims your quote will include? What is the limit?

Claims Administration

5. Describe in detail your procedures and time frames for reimbursement of claims exceeding the specific stop-loss level. Please give a clear description of the overall procedure you utilize from start to finish in reimbursing the policyholder, including your interaction with the claims administrator, utilization review firm, and large case management service.

6. Please describe how you would coordinate with the case manager regarding a large claim? Who would contact the claimant? How would a case plan be established?

7. Please provide a detailed description of all reporting and/or notification requirements for which the Agency will be responsible. Also, indicate the report frequency and include samples of any forms that must be completed.

Contractual Issues

8. Define clearly the terms and conditions of your contract as they apply to termination.

9. What is the maximum time allowed for submission after the termination date of valid claims that were paid within the contract period?

10. Are you willing to accept the Agency's records as the final authority on enrollment? If not, what documentation is required?

11. Will you waive any pre-existing condition limitation on the original effective date to the extent satisfied under the current plan?

12. Provide a sample contract for specific stop-loss insurance.

13. What type of terminal liability coverage would be provided if a paid stop loss contract were to be terminated? Please describe the terms and requirements of your coverage.

14. Describe the insurer's definition of experimental procedures and how this is interpreted for a claim approved for payment under the medical plan.

15. Describe the notification and reimbursement procedures, including who is reimbursed (ADOA or the claims administrator) and the frequency of reimbursement (monthly, quarterly, etc.)

16. Mandatory: Provide a formal declaration of exclusions and complete the Statement of Compliance below.

Specific Stop-Loss Statement of Compliance

Please indicate your willingness to enter into a paid contract that would reimburse claims regardless of the incurral date. Provide the impact this would have on your rates quoted on the enclosed exhibit.

Please note the following:

17. Specific stop-loss coverage should be quoted on a 15/12 basis for 2004 - you will be liable for all claims paid during the contract period that were incurred from this date forward: October 1, 2004. Please quote on $200,000, $300,000. and $400,000 attachment points. For 2005 forward, please assume a 12 month paid basis.

COMMUNICATIONS

Please answer the following questions and submit the requested materials and information as part of your firm's response to this RFP.

Communication Media

Print

- What is your capability and experience in providing ongoing printed communication materials that include information about disease management, demand management, pharmacy programs, medical care, and other programs you offer? How much of this material will you provide the State of Arizona and is it included in your pricing? Please provide samples of these items.
- What is your capability and experience in providing printed materials that include information about transitional issues such as changing a PCP, transition of care, open enrollment, and other events? How much of this material will you provide the State of Arizona and is it included in your pricing? Please provide samples of these items.
- How frequently does your firm update its printed provider directories? Please submit a copy of the printed provider directory.
- What is your approach to distribution of printed member materials? Do you send these materials via mail, email, or other methods?
- Describe how you handle production and shipping costs for printed materials. Will the State of Arizona be billed for additional costs on top of negotiated fees?
- Are there additional costs for customizing the printed materials you provide? If so, what are these costs?

Online

- Describe your overall objective or philosophy behind providing members with web-accessible information, tools, and transactions.
- What is your capability and experience providing ongoing online communication materials and resources via website that include information about disease management, demand management, pharmacy programs, medical care, and other transactional processes that can be handled online? How much of this material will you provide the State of Arizona and is it included in your pricing? Please provide a URL and dummy password to your site.
- What is your capability and experience in providing online materials that include information about transitional issues such as changing a PCP, transition of care, open enrollment, and other transactional processes that can be handled online? How much of this material will you provide the State of Arizona and is it included in your pricing?
- Confirm that you offer provider directories online and describe the approach to keeping the online directory up to date as well as the frequency of updates.

- Describe your initial approach to promoting the online communication materials and tools you provide so that members are aware of them and register to use them (if there is a registration process).
- Describe your ongoing approach, after the initial launch, to ensure continued use of your online resources.
- Explain how State of Arizona employees would access your online materials and tools.
- Describe the required computer hardware and software specifications necessary for accessing the online materials you provide.
- Explain your approach to and experience with providing support for online communication materials and tools. Do you offer any ongoing support for problems with access or navigation of the online materials you provide?
- Are there additional costs for customizing the online materials you provide? If so, what are these costs?

Face-to-Face

- What is your capability and experience providing face-to-face communication that includes information about transitional issues such as changing a PCP, transition of care, open enrollment, and other events on an as-needed basis? What resources and deliverables will be made available to the State of Arizona to assist with this process?
- What is your capability and experience providing face-to-face communication on an ongoing basis?
- Please provide a sample of a presentation that would be used in a meeting with members.
- Are there additional costs for utilizing face-to-face communication during the year? If so, what are these costs?

Customization

- To what extent can the State of Arizona customize the printed materials that you provide? To what extent can the State of Arizona add its own logos, change text, and personalize information?
- To what extent can the State of Arizona customize the online materials, tools, and the overall website that you provide? Please indicate the extent to which the State of Arizona can add its own logos, change text, and personalize information?

Content

- What is the average reading grade level of communication materials you provide?
- What languages are available in print?
- What languages are available online?
- How frequently do you update the printed communication pieces you provide?
- Describe your process for maintaining your website to ensure there are no broken links, content is up to date, and the site is functioning properly.

Experience and Approach

- Do you have experience using communication channels other than the ones mentioned in this section? What other communication channels have you had experience using?
- Please provide samples of any other types of communication you have available.

REPORTING

Systems and Data Reporting/Management

1. Are you able to provide standard reporting (eligibility and claim data) on a monthly or quarterly basis?

2. Is there an additional charge for ad hoc reporting?

   ❒ Yes ❒ No

   Average per report $_____

3. Do you have a reporting system that is available to clients for use via the Internet for standard and ad hoc reporting? If yes, please describe its capabilities.

   ❒ Yes ❒ No Additional fee $_____

4. Will you accept fiduciary responsibility for claims and appeals? Please include any cost in the appropriate place in the *financial* section.

5. ADOA is requesting that the following reports are provided on a monthly basis. Confirm that you are willing and able to provide the reports. If you answer "no", please give a detailed explanation as to why you are not able or willing to provide the reports. Please provide examples of the reports you answer "yes" to as well as any other standard reports you would like ADOA to see.

Monthly Reports	Yes	No
Enrollment, claims paid (including any capitation and prescription drug claims) and premium paid	?	?
Large claim reports identifying members with claims of $25,000 or more within the plan year	?	?
Number of checks processed	?	?
Enrollees (employees) and members by product	?	?
Earned premiums	?	?

6. ADOA is requesting that the following reports are provided on a quarterly basis. Confirm that you are willing and able to provide the reports. If you answer "no", please give a detailed explanation as to why you are not able or willing to provide the reports. Please provide examples of the reports you answer "yes" to as well as any other standard reports you would like ADOA to see.

Quarterly Reports	Yes	No
Claim lag report (incurred vs. paid)	?	?
Utilization and cost report, including:	?	?

- hospital admissions, days, average length of stay and cost per stay - hospital outpatient services, including emergency room visits and costs - inpatient and outpatient surgeries and cost - physician office visits, urgent care visits and therapy visits - radiology and lab services and procedures - prescriptions, separate for generic, preferred brand and non-preferred brand		
Physician office visits/1,000 members	?	?
Prescriptions/1,000 members	?	?
Total claims billed, allowed and paid by medical service category	?	?
Claim costs by type of service (medical inpatient, outpatient, physician, etc.)	?	?
In-network vs. out-of-network utilization and claims cost for claims billed, allowed, and paid	?	?
Savings resulting from network discounts, exclusions, reductions from U&C, COB, etc.	?	?
Pharmacy utilization, including top 50 drugs by volume and cost and reported results from DUR and other pharmacy management programs and interventions	?	?

7. ADOA is requesting that the following reports are provided on an annual basis. Confirm that you are willing and able to provide the reports. If you answer “no”, please give a detailed explanation as to why you are not able or willing to provide the reports. Please provide examples of the reports you answer “yes” to as well as any other standard reports you would like ADOA to see.

Annual Reports	Yes	No
Monthly and quarterly reports as mentioned in previous tables	?	?
Enrollment (employees and dependents) demographics with age and gender breakouts by plan type	?	?
Annual utilization, cost and savings report	?	?
Patient outcomes (in terms of mortality and morbidity)	?	?

8. ADOA is requesting the monthly and quarterly reports are delivered to the Agency 45 days after the close of the period, and the annual reports are delivered 60 days after the end of the year. Please confirm you are willing and able to complete this request and timeframe.

Pharmacy

9. ADOA is requesting that the following reports are provided on a monthly basis. Confirm that you are willing and able to provide the reports. If you answer "no", please give a detailed explanation as to why you are not able or willing to provide the reports. Please provide examples of the reports you answer "yes" to as well as any other standard reports you would like ADOA to see.

Monthly Reports	Yes	No
Narrative or newsletter on clinical developments, such as major new drugs, drugs moving to generic or OTC	?	?
Number of prescriptions, average wholesale ingredient costs, discounted ingredient costs charged, employee copays, dispensing fees and amount paid, split between retail and mail order, and between single-source brand, multi-source brand, and generics	?	?
Claims lag reports, showing total payments by incurred and paid months	?	?
Covered membership reports, showing total counts of covered employees/retirees and covered members (including dependents)	?	?
All reports split between actives, retirees, combined or within requested parameters as indicated by the Agency	?	?

10. ADOA is requesting that the following reports are provided on a quarterly basis. Confirm that you are willing and able to provide the reports. If you answer "no", please give a detailed explanation as to why you are not able or willing to provide the reports. Please provide examples of the reports you answer "yes" to as well as any other standard reports you would like ADOA to see.

Quarterly Reports	Yes	No
Year-to-date summaries of the monthly summary reports	?	?
Quarterly performance standards results	?	?

11. ADOA is requesting that the following reports are provided on an annual basis. Confirm that you are willing and able to provide the reports. If you answer "no", please give a detailed explanation as to why you are not able or willing to provide the reports. Please provide examples of the reports you answer "yes" to as well as any other standard reports you would like ADOA to see.

Annual Reports	Yes	No
Management summary	?	?
Full financial and enrollment experience	?	?
Top 100 brand drugs and top 100 generic drugs	?	?
Provider profiling/other clinical effectiveness reports	?	?

Care Management

12. Confirm the type of reporting you provide to clients for your disease management programs. Please provide examples or your standard reports provided to employer clients.

			If Yes,		
	Yes	No	Monthly	Quarterly	Annually
Identified Participant Candidates	?	?	?	?	?
Enrolled Participants	?	?	?	?	?
Participants by disease	?	?	?	?	?
Participants by disease and level of acuity	?	?	?	?	?
Participant Satisfaction	?	?	?	?	?
Physician Satisfaction	?	?	?	?	?
Client Satisfaction	?	?	?	?	?
Claims Savings – Medical Only	?	?	?	?	?
Claims Savings – Rx Only	?	?	?	?	?
Claims Savings – Diagnosis Specific	?	?	?	?	?
Claims Savings – Total	?	?	?	?	?
Absenteeism	?	?	?	?	?
Occ or Non-Occ Disability	?	?	?	?	?
Productivity	?	?	?	?	?
Quality of Life	?	?	?	?	?
Clinical Outcomes (please provide standard metrics used)	?	?	?	?	?
Risk Reduction	?	?	?	?	?
Functional Capacity	?	?	?	?	?
Participation frequency - % of recommended contacts per enrollee	?	?	?	?	?
Utilization - % of eligible lives per condition	?	?	?	?	?
Outreach Success to Attract High Risk	?	?	?	?	?

Questionnaire

SOLICITATION NO.: AD040404

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Offeror: _____

State Procurement Office

100 North 15th Avenue

Suite 104

Phoenix, AZ 85007-3223

			If Yes,		
	Yes	No	Monthly	Quarterly	Annually
Other: _____	?	?	?	?	?

MEDICARE PLUS CHOICE PLAN

If ADOA determines it would like to offer Medicare Plus Choice (M+C) coverage to its Medicare Part A and B eligibles, ADOA would like to know if your organization would be prepared and willing to provide M+C benefits and offerings. Based on the following questions, please provide information regarding your ability and/or willingness to operate an M+C plan for ADOA Medicare eligibles.

1. Does your organization operate a M+C plan? If so, would you make available to the Agency?
2. If your organization does not operate an M+C plan, discuss how you would intend to cover the Medicare Part A and B eligibles for the period of October 1, 2004 through December 31, 2004. If you would not intend to offer a M+C plan, please answer with "Do not intend to offer" below.
3. Identify the M+C product type your organization would choose if asked to do so by the Agency.
   - ❍ HMO
   - ❍ PPO
   - ❍ POS
   - ❍ PSO
   - ❍ Other *(please specify)* _____

In addition to the products listed above, does or will this plan offer a Medicare supplement plan?

❍ Yes ❍ No

4. If you are a current M+C plan, please provide the following membership numbers for this plan only. Please do not round membership numbers to the nearest 1,000.

Total number of this plan's M+C members as of January 1, 2003	# _____
Total number of this plan's M+C members as of December 31, 2003	# _____
Total number of this plan's M+C members who disenrolled between January 1, 2003 and December 31, 2003	# _____
Total number of this plan's M+C members as of January 1, 2004	# _____

5. Would you offer the basic benefits as required by CMS?
6. Would you be willing to provide benefits other than the basic as shown in the table below? Please indicate which of the following would be included in your basic benefit package, or offered only as an additional/mandatory/optional supplemental benefit, or not covered.

Term	Definition
Basic	Health care services covered as part of the standard benefit package.
Additional Benefit	Health care services not otherwise covered by Medicare. Additional benefits are specified by the M+C organization and are offered to Medicare beneficiaries at no additional premium.
Mandatory	Health care services not covered by Medicare which beneficiaries must purchase as a condition of enrollment in a M+C plan. Usually these services are paid for by premiums and/or cost sharing. Mandatory supplemental benefits can be different for each M+C plan offered by a M+C organization. Mandatory supplemental benefits may not be used to encourage or discourage enrollment.
Optional	Services not covered by Medicare that beneficiaries may choose to purchase for additional plan premium. Optional supplemental benefits are offered individually or combined into groups and may differ for each M+C plan.

	Questionnaire		State Procurement Office
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Benefit	Basic	Additional	Mandatory	Optional	Not Covered
Annual Physical Exam	❍	❍	❍	❍	❍
Chiropractic Care	❍	❍	❍	❍	❍
Dental Care (in addition to required)	❍	❍	❍	❍	❍
Durable Medical Equipment	❍	❍	❍	❍	❍
Routine Foot Care	❍	❍	❍	❍	❍
Foreign Travel Coverage	❍	❍	❍	❍	❍
Hearing Screening	❍	❍	❍	❍	❍
Hearing Aids	❍	❍	❍	❍	❍
Immunizations	❍	❍	❍	❍	❍
Inpatient Mental Health	❍	❍	❍	❍	❍
Intermediate and Long-Term Care	❍	❍	❍	❍	❍
Long-Term Physical Medical / Rehab	❍	❍	❍	❍	❍
Outpatient Mental Health	❍	❍	❍	❍	❍
Physical Therapy	❍	❍	❍	❍	❍
Prescription Drugs	❍	❍	❍	❍	❍
Retail Generic	❍	❍	❍	❍	❍
Retail Brand	❍	❍	❍	❍	❍
Mail Order	❍	❍	❍	❍	❍
Private Duty Skilled Nursing	❍	❍	❍	❍	❍
Private Duty Unskilled Nursing	❍	❍	❍	❍	❍
Transportation	❍	❍	❍	❍	❍
Vision Screening	❍	❍	❍	❍	❍
Additional Vision Care (including eyeglasses and contact lenses)	❍	❍	❍	❍	❍

HIPAA

Please review ADOA's Business Associate Agreement in the Data Library and indicate your willingness to execute this agreement. Please provide a copy of your standard contract language related to HIPAA.

Privacy Requirements

A = agree D = agree with deviations N = no	A	D	N
1. You will ensure that all necessary policies, procedures, patient authorization forms, etc. of the plan comply with applicable Privacy provisions of state law, to the extent such state law is not preempted by the provisions of HIPAA. If your answer to the above is No, please comment regarding the status or timeline for compliance with these requirements.	_____	_____	_____

A = agree D = agree with deviations N = no

	A	D	N
2. You satisfy all applicable privacy requirements of HIPAA, including:	_____	_____	_____

- Amendment of your documents to properly restrict the use and disclosure of Protected Health Information (PHI).
- Automatic delivery of a privacy notice (meeting the content and time-of-distribution requirements of the regulation), including a disclosure that you may provide information beyond "summary health information" to the plan sponsor for purposes of administrative functions.
- Execution of a written contract (meeting the content requirements of the regulation) with each "business associate" of yours.
- Designation of a privacy officer.
- Erection of physical barriers and electronic "firewalls" to safeguard PHI.
- Establishment of processes to provide individuals with access to their PHI (including an accounting of non-routine disclosures) and the right to amend that information.
- Receipt of "consents" and "authorizations" (meeting the content requirements of the regulation) from individuals, as appropriate.
- Training of your employees on privacy policies/procedures.
- Creation of a process for individuals to lodge complaints, a system for handling complaints, and a method of tracking complaints/resolutions.
- Adoption of a written disciplinary policy and sanctions for your employees who violate the privacy rules.

If your answer to the above is No, please comment regarding the status or timeline for compliance with these regulations.

A = agree D = agree with deviations N = no	A	D	N
3. You will disclose health information beyond "summary health information" to plan sponsor personnel for purposes of plan administration, if requested, upon ADOA's appropriate assurances as to compliance with the relevant HIPAA privacy requirements. If your answer to the above is No, please comment.	_____	_____	_____
4. You require your subcontractor(s) to maintain privacy policies regarding individual health information. You have updated your contracts to require HIPAA privacy compliance as of April 14, 2003. If your answer to the above is Yes, please enclose a copy of the contract with the other materials submitted in support of your proposal.	_____	_____	_____
5. To the extent applicable, you will also satisfy all relevant HIPAA privacy requirements imposed upon the organization in its capacity as a "provider" (as defined in the regulation). If your answer to the above is No, please comment.	_____	_____	_____

Certificate of Insurance

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State Procurement Office

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Prior to commencing services under this contract, the contractor must furnish the state certification from insurer(s) for coverages in the minimum amounts as stated below. The coverages shall be maintained in full force and effect during the term of this contract and shall not serve to limit any liabilities or any other contractor obligations.

Name and Address of Insurance Agency:	**Company Letter:**	**Companies Affording Coverage:**
	A	
	B	
Name and Address of Insured:	C	
	D	

LIMITS OF LIABILITY MINIMUM - EACH OCCURRENCE		**COMPANY LETTER**	**TYPE OF INSURANCE**	**POLICY NUMBER**	**DATE POLICY**
Bodily Injury			Comprehensive General Liability Form		
Per Person			Premises Operations		
Each Occurrence			Contractual		
Property Damage			Independent Contractors		
or			Products/Completed Operations Hazard		
Bodily Injury			Personal Injury		
and			Broad Form Property Damage		
Property Damage			Explosion & Collapse (If Applicable)		
Combined			Underground Hazard (If Applicable)		
Same as Above			Comprehensive Auto Liability Including Non-Owned (If Applicable)		
Necessary if underlying is not above minimum			Umbrella Liability		
Statutory Limits			Workmen's Compensation and Employer's Liability		
			Other		

State of Arizona and the Department named above are added as additional insureds as required by statute, contract, purchase order, or otherwise requested. It is agreed that any insurance available to the named insured shall be primary of other sources that may be available.

It is further agreed that no policy shall expire, be canceled or materially changed to affect the coverage available to the state without thirty (30) days written notice to the State. This Certificate is not valid unless countersigned by an authorized representative of the insurance company.

Name and Address of Certificate Holder:

Date _____

_____

Authorized Representative

End of Solicitation AD040404 Document